Reside Care Homes Limited

Reside at Stour Road

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Good**
Is the service caring?	**Good**
Is the service responsive?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

Say when the inspection took place and whether the inspection was announced or unannounced. Where relevant, describe any breaches of legal requirements at your last inspection, and if so whether improvements have been made to meet the relevant requirement(s).

Provide a brief overview of the service (e.g. Type of care provided, size, facilities, number of people using it, whether there is or should be a registered manager etc).

N.B. If there is or should be a registered manager include this statement to describe what a registered manager is:

'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.'

Give a summary of your findings for the service, highlighting what the service does well and drawing attention to areas where improvements could be made. Where a breach of regulation has been identified, summarise, in plain English, how the provider was not meeting the requirements of the law and state 'You can see what action we told the provider to take at the back of the full version of the report.' Please note that the summary section will be used to populate the CQC website. Providers will be asked to share this section with the people who use their service and the staff that work at there.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Risk assessments were completed but actions to minimise risk were not always effectively managed.

People were supported by staff who understood how to recognise abuse and the actions they needed to take if they felt a person was at risk of abuse.

People were supported by enough staff who had been recruited safely.

Medicines were stored and administered safely.

Is the service effective?

Good

The service was effective.

Staff received an induction, ongoing training and supervision that gave them the skills to carry out their roles effectively.

People were supported by staff that understood the principles of the mental capacity act.

People's eating and drinking needs were met.

People had access to healthcare in an appropriate and timely way.

Is the service caring?

Good

The service was caring.

Relationships between people and the staff team were positive, kind and caring.

Staff understood people's individual communication needs which enabled them to be involved in day to day decisions.

People had their dignity and privacy respected and their independence encouraged.

Is the service responsive?

Good

The service was responsive.

People had care and support plans that clearly described their assessed needs and staff understood the actions they needed to take to support them.

Information about people's life's, hobbies and interests were used to plan meaningful activities.

A complaints process was in place and families felt if they used it they would be listened to and actions taken when appropriate.

Is the service well-led?

Requires Improvement

The service was not always well led.

The provider did not did not always meet their responsibilities for sharing information with CQC.

Audits had not all been effective in providing information that led to improved outcomes for people. When audits had identified improvements were required actions had been taken promptly.

Staff understood their roles and responsibilities and had opportunities to share ideas at regular staff meetings.

People, families, staff and other professionals had opportunities to provide feedback about the service through an annual quality assurance survey.

Reside at Stour Road

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 the 29 December 2016 and was unannounced. It continued on the 3 January 2017 when it was announced. The inspection was carried out by a single inspector.

Before the inspection we looked at notifications we had received about the service and we spoke with social care commissioners and the local safeguarding team to get information on their experience of the service Before the inspection, we asked the provider to complete 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. They did not return a PIR and we took this into account when we made the judgements in this report.

During our inspection we spoke with one person who used the service and four relatives. We spoke with the registered manager, deputy manager, chef, administrator and four care workers. We also spoke with a district nurse and community mental health nurse who had experience of the service. We reviewed four people's care files and discussed them with relatives and care workers to check their accuracy. We looked at three staff files, care records and medication records, management audits, health and safety records and the complaints log. We walked around the building observing the safety and suitability of the environment and observing staff practice.

Requires Improvement

Is the service safe?

Our findings

People at risk of pressure damage to their skin were not always having their risk effectively managed. People had their risk of skin damage assessed on admission to the service and where risks were identified actions were detailed in the person's care and support plan. Actions to minimise risk included people having specialist pressure relieving air mattresses on their beds. In order to offer protection to people the air pressure must be set according to the person's weight. Some mattresses were self-regulating and adjusted to the person's weight automatically. A daily audit of air mattresses had been put in place to ensure they were working effectively and protecting people.

On the first day of our inspection we found this process was not operating effectively which meant people were not being fully protected from risk of skin damage. We found one mattress was beeping to indicate a fault and showing a recording of low pressure. We returned to the room later in the day with the registered manager and the fault alarm was still beeping. A daily check of the air mattress had not been completed so we were not able to establish how long the mattress had been displaying a fault. The registered manager explained that any faults should be reported to the person in charge and recorded in a maintenance log. This had not taken place. We looked at another person's air mattress and the reader was blank and not showing any setting at all. We were told by a care worker the setting display should read low, medium or high. The audit for the day stated 'working'. We felt the air mattress and it was inflated but it was not possible to determine if the setting was correct. The daily check form showed that on the 3 December 2016 the fault alarm was beeping. We checked the maintenance book with the registered manager and this had not been reported. Records for the 5 – 29 December stated 'working'. One person had a mattress that needed to be manually set. When we checked the mattress setting in the morning it had been set at 90. We returned with the registered manager in the afternoon and found the setting remained at 90. The registered manager confirmed the setting should have been set at 45 and asked staff to reduce the setting to reflect the person's weight.

We discussed our findings with the registered manager and on the second day of our inspection we checked each room and found all the air mattresses working and set correctly. They told us the mattress checking process had been reviewed and that they or the deputy manager would carry out an additional check each day to ensure this continued. A maintenance check had been made and any faulty mattresses repaired or changed. Training was being organised to ensure staff understood the correct way to operate different types of specialist air pressure mattresses.

Some people needed to be supported by staff to change position regularly in order to relieve pressure on their skin. We checked people's re-positioning charts over a one month period and found these had been completed appropriately. Staff had been recording the times they had supported people to change position in line with the persons care and support plans. Some people needed to sit on pressure cushions when out of bed in order to minimise risk of damage to their skin. We observed that this was taking place appropriately. We spoke with a district nurse who told us that they had supported a person living at the home who had pressure issues. They told us their care had not been compromised and staff had provided the appropriate care to minimise any risks.

Risk assessments included general health and safety of the environment. A health and safety audit of the building carried out by the registered manager on the 28 October 2016 identified that an external door into the secure back garden was not linked to the security sensor alarm system and could be a potential risk to people's safety. The risk assessment had not identified any specific person to be at risk. The registered manager explained that they had contacted a company to get a quote for the door to have a sensor alarm fitted and be connected to the fire alarm system. They were waiting for the company to visit and carry out a survey and provide a quote. The night before our inspection a person had gone out the door and had a unwitnessed fall in the garden. We checked records and found the person had no history of falls. During our inspection the registered manager spoke with the alarm company who confirmed they would make the survey and work a priority. Temporary management plans were put into place to minimise the risk of a further incident until the work was completed. This demonstrated that when risks changed immediate actions were taken to minimise risks to people.

Accident and incident forms were completed and reviewed by the management team. Actions were put in place to minimise the risk of the accident or incident happening again. An example included a person who had a fall in their bedroom and a pressure sensor alarm mat had been put in place to alert staff they may need assistance when out of bed.

People had personal evacuation plans which meant staff had an overview of what support each person would require if they needed to leave the building in an emergency

People's risk of malnutrition had been assessed and reviewed at least monthly. Records showed us that one person had been losing weight. Actions had been put in place to minimise the risk of further weight loss and included having their food fortified with extra calories and a referral being sent to a speech and language therapist for a swallowing assessment. We spoke with staff who were able to tell us what actions had been put in place. One care worker said "(Name) has been losing weight, quite often refuses diet and says things like 'leave me alone'. They have been a little better later. They are having a soft diet with extra calories".

Families and external professionals with experience of the service told us they felt the care was safe. One relative told us "I feel it's safe. The staff are very careful about the door access and people coming in and going out". We spoke with a mental health nurse who told us "From what I've seen the care feels safe. People were attended to if they called out and staff were vigilant". Staff had completed training and understood what types of abuse people could be at risk from, what signs to look for and the actions they needed to take if they suspected abuse. A care worker told us "I definitely feel people who live here are safe. If not I would go to CQC or the police". We saw that posters were on noticeboards around the service. These provided information to people, and their visitors of whom to contact if they had concerns about people's safety.

People were supported by enough staff who had been recruited safely. Relevant checks were undertaken before people started work. For example references were obtained and checks were made with the Disclosure and Baring Service to ensure that staff were safe to work with vulnerable adults. A relative told us "Staff don't do 1-1 but they address each person in turn. There are usually staff about". A district nurse told us "There are enough staff and they are quick in showing us where we need to go". During our inspection we saw that people were being supported with their care needs in a timely way and staff had time to spend talking and sharing activities with people and their families. When we spoke with staff they had mixed views on staff deployment. One told us "Staffing is OK. I have worked days and nights. During the day there may be too many". We spoke with two care workers who shared their concerns that between 6 – 8pm there had been the occasional time when the lounge had been left unsupervised if people were being supported with personal care. The staffing levels after six in the evening Monday to Friday reduced to three staff once the

registered manager left. At weekends staffing remained at four staff until the night team started their shift at 8pm. We discussed this with the registered manager who explained that they were constantly reviewing flexible ways of deploying staff across the 24 hour day to meet the changing needs of people. At the time of our inspection they felt the staffing levels met the needs of people living at the service. One of the indicators the registered manager explained was the low level of reported falls.

People had their medicines ordered, stored and administered safely. Care and support files contained information about the medicines people had and explained what they were being taken for and how they worked. An example was a diuretic prescribed as a water pill used to reduce swelling and fluid retention. When people had been prescribed a cream a body map had been completed showing where the cream needed to be applied and a record had been completed to confirm it had been administered. Some people had been prescribed medicines for as and when needed. Each of these medicines had a written protocol describing what the medicine had been prescribed for and how often it could be administered. An example was an analgesic. The person was unable to verbalise they were in pain and the protocol included signs for staff to look for as an indicator they may require an analgesic. Medicines were reviewed regularly. One person's medicine had been reviewed by the community mental health team and we saw that one medicine had been changed to a lower dose. This meant that people were at a reduced risk of taking unnecessary or inappropriate medicines.

Good

Is the service effective?

Our findings

People were supported by staff that had completed an induction and on-going training that enabled them to carry out their roles effectively. New care staff completed the Care Certificate induction course. The Care Certificate is a national induction for people working in health and social care who have not already had relevant training. We spoke with the deputy manager who told us "We normally arrange for new staff to shadow shift for about a week". One relative told us "The staff seem skilled". One care worker told us about how their dementia training had helped them in their role. They told us "It makes you learn how to work with people. Each resident is different but training helps us understand". They continued to explain how one person had behaviours that they were able to understand and support the person with with once they learnt they were linked to a past job. We spoke to a nurse who had been providing training to staff. They told us "The service are always keen to take me up on training, subjects have included record keeping and communication. The staff who attend give me time to talk, they are attentive".

Staff told us they felt supported. They received regular supervision and an annual appraisal. Opportunities were available for professional development. One care worker told us "(The registered manager) is good at pushing more training". Another told us "I have supervision about every three months. I have an appraisal and have just finished my level three diploma (in health and social care). I feel supported by the manager".

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 legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (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.

The service was working within the principles of the MCA. Staff were aware of the Mental Capacity Act and training records showed that they had received training in this. The service completed capacity assessments and recorded best interest decisions. This ensured that people were not at risk of decisions being made which may not be in their best interest. DoLS had been applied for appropriately. One person had conditions on their authorisation and these were being met. Files contained copies of power of attorney legal arrangements for people and staff understood the scope of decisions they could make on a persons' behalf.

One person told us "The food is lovely". Another relative told us "The food always looks good. (Relative) needs encouraging to eat. There's always a drink available". Care and catering staff had a good knowledge

of people's eating and drinking requirements. One relative said "(Name) enjoys fish. The chef purees it which is great. He is eating more now. He varies, sometimes he uses a knife and fork and other times needs help". We observed two lunch time meals and the food looked appetising. The menu offered two main choices but we observed people having alternatives. We heard one person ask for bread and cheese rather than the desert. People were supported to be as independent as possible by having their food and drink served in specialist beakers or the use of a plate guard. When people needed assistance with their meal we observed staff supporting them at their pace. At the time of our inspection nobody was experiencing swallowing difficulties when eating and drinking however when needed referrals had been made to the swallowing and language team to carry out assessments and provide advice.

People had access to healthcare and records showed us this had included opticians, dentists, GP's, district nurses, chiropodists, community mental health team and dieticians. A care worker told us "If I'm concerned about health problems I would call 111 for advise if I'm not sure and if more serious 999 or the persons GP".

Good

Is the service caring?

Our findings

We observed positive, caring relationships between people and the whole staff team. We observed the housekeeper chatting to people as they polished the coffee tables and involving a person in helping them sort out laundry. We observed one person becoming a little anxious about where they were. The administrator had been walking past and stopped and provided comfort and reassurance which visibly reduced the person's anxiousness. On another occasion we saw a person starting to get agitated and shouting questions out. A care worker sat with them and calmly and patiently offered reassurance and explanations to their questions. Conversation between staff and people demonstrated that staff had a good knowledge of the people they were supporting.

Relatives described staff as caring and kind. One relative told us "We are very pleased with (name's) care. (Name) is frail but sometimes well enough to go into the lounge. (Name) is better in bed and they (staff) come straight away and help me and leave (name) nice and cosy in bed". Another relative told us "We have been very pleased with the way (relative) is looked after. Staff are helpful and keep us up to date. (Relative) is always clean and tidy. (Relative's) skin needs a lot of moisturising and especially when hot. They leave hand cream next to (relative) and will regularly rub it in". Another said "Staff are caring and respectful and I feel really understand (name)". We read a letter from a relative that included 'We 100% feel that residents are dealt with dignity and respect. We like the interaction between staff and relatives. On visits all staff are friendly". A care worker told us "We're like a big family with residents and their families. We have a nice relationship with the families".

People were involved in decisions about their day to day lives. We observed staff asking people where they would like to sit, if a person appeared tired they would ask if they wanted to have a rest in their room. We heard one person say to a care worker "Should I go to bed". They responded by saying "(Name) it's up to you, do you want to go to bed, to go upstairs"? They explained the time of day and what other options the person had such as joining in a planned sing along. We observed one person mid-afternoon ask a care worker "What time's lunch?". In addition to explaining times of meals the care worker explored if the person was hungry and offered to make a sandwich. This demonstrated that staff recognised the importance of listening and exploring the meaning and feelings behind words to help people communicate their needs and make informed decisions. The registered manager told us that advocacy information was available to people and could be accessed if needed.

We observed a board on the wall used to orientate people of the day, weather and season. Another board in the dining room was displaying in pictures meal options for the day. Both had incorrect information displayed which was not supporting people's orientation and independence. We discussed this with the registered manager who immediately addressed the issue. People had their privacy and dignity respected. A relative explained "If staff noticed (name) trousers were loose they would immediately disappear and get a pair of braces". Staff told us of another person who every evening liked to get ready for bed and then always asked to sit in a chair in their own room. We observed staff encouraging people with their independence. An example was a person using a walking aid to move about the home. Staff supported and encouraged, giving simple instruction to aid the person to turn and sit independently into an armchair. One care worker

told us "I always encourage people to be independent. An example would be with personal care. I say thinks like 'You help me to help you'. Perhaps suggest they use the flannel to wash their face but I help with more awkward areas like back or feet".

Good

Is the service responsive?

Our findings

Assessments had been completed before a person moved into the service and this information had been used to form their care and support plan. The plans contained clear information about people's assessed needs and the actions staff needed to take to support people. The care and support plans were holistic and included physical, psychological and social aspects of a person's life. When we spoke with and observed staff they demonstrated a good knowledge of how they needed to support people. One care worker told us "At each handover each person is discussed. It includes examples such as people who may not have been eating or drinking enough and would ask us to coax them; I feel the process is effective". We saw that care plans were reviewed monthly and a full care plan review took place six monthly. We spoke with a mental health nurse who explained how they had worked with the home in reviewing a person's anxiety. They told us "The manager was very receptive and listened and took actions. A 24 hour behavioural chart was introduced and completed by the staff. We were able to look at a pattern of behaviour and make changes to the times they received their medicine. It has really made a difference to their anxiety".

Information had been gathered on people's interests and hobbies and a range of activities took place in the home, garden and the wider community. A care worker told us about how they had taken one person to their old place of work. They explained "It enabled (name) to reminisce and chat about their life". They also described some other trips that people had taken into the local community. "We had a trip to Christchurch Priory and we lit candles for people who they had lost. We went out and bought our own pumpkins and we carved them here. People loved it and thought it was amazing". During our inspection we observed people reading the daily newspaper, playing games and sitting doing art work. Two people were playing a game of cards and using chocolate as the currency. One relative told us "(Relative) loves a singalong. They were singing along to music today when I arrived".

We asked staff what they did to ensure people who stayed in their rooms didn't become isolated. A care worker gave us examples, "(Name) was a church person so we will sit in their room and read parts of the bible to them. When (name) another resident is in bed you can sit and sing war time songs and (name) will sing along. You know they are enjoying themselves as they clap and sing a long".

We saw photographs of events through the year and they had included a raised vegetable bed where people had helped grow, harvest and eat the produce. There had been a sunflower growing competition where the winner of the tallest sunflower had been taken out for a pub lunch. Entertainment in the home had included regular visits from a classical violinist, a visiting Christmas pantomime and visiting alpacas.

A complaints procedure was in place and relatives told us they felt they would be listened to if they had a complaint. One relative told us "If I had a complaint I know it would be dealt with. Other family members often ask questions and it is never a problem". The registered manager told us that any complaint responses included a copy of the complaints procedure. These included details of external agencies complainants could go to if they felt their complaint had not been dealt with appropriately. The information needed to be updated to include details of the local government ombudsman. We discussed this with the registered manager who told us they would make the changes immediately. A compliments and

complaints book had been introduced and placed in the foyer. Visitors had been making entries complimenting the home.

Requires Improvement

Is the service well-led?

Our findings

When we last inspected in October 2015 there was a breach in regulation relating to good governance. The service had systems and processes in place to assess and monitor the service but did not take prompt action to improve some findings in relation to the environment. At this inspection we found that improvements had been made but more were needed.

The provider did not did not always meet their responsibilities for sharing information with CQC. In August 2016 we asked the provider to complete 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. The PIR had not been completed and our records showed us that the provider had failed to notify CQC of alternative contact details so that the request could be appropriately managed in the absence of a registered manager. This meant that information used to assist in assessing risk and planning our inspection had not been available. Other statutory notifications had been received appropriately. A notification is the action that a provider is legally bound to take to tell us about any changes to their regulated services or incidents that have taken place in them.

An auditing process was in place to monitor the use of air pressure mattresses. The audit had not been effective in recognising potential risks to people identified during our inspection. When these were discussed with the registered manager they had taken prompt and appropriate action to rectify the issues. Audits also included medicines, health and safety, infection control, cleaning, garden safety and building security. Where improvements had been identified the registered manager had instigated actions. Examples had been changes to the daily cleaning programme and replacement of furniture.

The registered manager worked to ensure ongoing improvement to the quality of care people received, the support and training available to staff and the physical environment. They had an ongoing programme of home maintenance and also had identified where the building could be improved to meet the needs of people living there. A new kitchen had been fitted and the Food Safety Agency had changed the rating from three to five stars. Furniture in the lounge and dining area had been replaced or cleaned and was in good condition. There were three chairs that remained to be replaced and this was planned for the following month. We read a comment from a relative that stated "The care home is so much better now in all respects; inside and out". We spoke with a care worker who told us that there had been problems with the boilers which had been affecting the hot water and heating system. They said "We spoke with the manager and they have now been replaced". The registered manager confirmed that two new boilers had been fitted which meant that there were no longer any issues with the hot water and heating". When we walked around the building we found all areas were clean and warm. Another care worker had suggested a raised border in the garden so that people could join in with planting. We saw that this idea had been implemented and enjoyed by people through the summer. This meant that staff felt empowered to share ideas and suggestions.

The registered managers office was directly off the communal lounge and therefore visible to people, their families and staff. We observed an open door culture which created a relaxed atmosphere and promoted

inclusion of people, their families and staff. One care worker told us "(Registered manager) is very resident focused. He mixes with residents and makes them a cup of tea". We spoke with a relative who told us "If I ring up the telephone is answered immediately". Another had written a letter which stated 'We have been impressed with the manager (registered manager), with the changes within the home and are grateful for keeping us involved with decisions'. We spoke with a district nurse who told us "We had some communication issues with the service. The manager was very quick to have a meeting to sort things. Communication is much better now".

Regular meetings had taken place to share information with staff. We read staff meeting minutes and topics had included care plans, dignity, respect, teamwork and communication. Meetings included details of who was responsible for any actions and dates for when they needed to be completed. We read supervision notes which detailed discussions with staff about aspects of their role and responsibilities. This meant that staff understood what their roles and responsibilities were which for some included becoming a champion of different aspects of care. Examples included a medication, dignity and a dementia champion. The registered manager told us they were planning to introduce management and staff focus groups to look at how they can further improve the delivery of care within the home.

An annual quality assurance survey had been completed in early 2016 prior to the appointment of the registered manager and the overall feedback from staff and families had been positive. The registered manager told us the process was due to begin again. This meant people were encouraged to contribute to the quality of the service.