Country Court Care Homes Limited

The Red House

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

Summary of findings

Overall summary

The Red House is registered to provide accommodation for up to 24 people requiring nursing or personal care, including people living with dementia.

We inspected the home on 5 April 2017. The inspection was unannounced. There were 20 people living in the home on the day of our inspection.

The home had a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers (the 'provider') 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.

CQC is required by law to monitor the operation of the Mental Capacity Act, 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) and to report on what we find. DoLS are in place to protect people where they do not have capacity to make decisions and where it is considered necessary to restrict their freedom in some way, usually to protect themselves. At the time of our inspection the provider had submitted 10 DoLS applications to the local authority and was waiting for these to be considered.

At our previous inspection in January 2015 we rated the home as Good. However, on our inspection of 5 April 2017, we found several areas in which improvement was required to ensure people received the safe, caring and responsive service they were entitled to expect.

Daytime staffing resources were not deployed effectively to meet people's needs and preferences. The management of some potential risks to people's safety and welfare was not consistently effective and the provision of communal activities and other events was confused and unstructured and did not consistently meet people's needs for stimulation and occupation.

Some staff used old-fashioned, institutional terminology when talking about people in their care and one person's right to privacy was not fully respected. Staff did not always reflect the content of people's individual care plans in the support they provided.

In other areas, we found the provider was meeting people's needs effectively.

There was a comfortable, relaxed atmosphere. Staff knew people as individuals and provided support in a friendly way. Staff understood the principles of the MCA and worked alongside local healthcare services to ensure people had access to any specialist support they required. People were provided with food and drink of good quality that met their individual needs and preferences.

Staff worked together in a supportive way and were provided with regular supervision and support by the registered manager and other senior staff. The provider organised a varied programme of training and

encouraged staff to study for advanced qualifications. The registered manager provided strong leadership and had won the respect and loyalty of her team.

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 consistently safe.

The deployment of daytime staffing resources did not consistently meet people's needs and preferences.

The assessment and management of potential risks to people's individual safety and welfare were not consistently effective.

People's medicines were managed safely.

Staff knew how to recognise and report any concerns to keep people safe from harm.

New staff were recruited safely.

Is the service effective?

Good

The service was effective.

Staff understood the principles of the Mental Capacity Act 2005 and reflected these in their practice.

The provider organised a varied programme of staff training and encouraged staff to study for advanced qualifications.

Staff were provided with regular supervision and support from the registered manager and other senior staff.

Staff worked closely with local healthcare services to ensure people had access to any specialist support they needed.

People were provided with food and drink of good quality that met their needs and preferences.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People's privacy and dignity were not consistently promoted.

Staff supported people in a friendly way.

Staff encouraged people to maintain their independence and to exercise choice and control over their lives.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

The provision of communal activities and other forms of stimulation was inconsistent and did not fully meet people's needs and preferences.

People had comprehensive individual care plans but staff did not always reflect their content in the care and support they provided.

Any complaints or concerns were managed effectively.

Is the service well-led?

Good

The service was well-led.

Staff worked together in a friendly and supportive way.

The registered manager provided strong leadership and had won the respect and loyalty of her team.

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The Red 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. The inspection was planned to check whether the provider was 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.

We visited The Red House on 5 April 2017. The inspection team consisted of an inspector, a specialist advisor whose specialism was nursing and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The inspection was unannounced.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form the provider completes to give some key information about the home, what the home does well and improvements they plan to make. The provider returned the PIR and we took this into account when we made the judgements in this report.

In preparation for our visit we also reviewed information that we held about the home such as notifications (events which happened in the home that the provider is required to tell us about) and information that had been sent to us by other agencies.

During our inspection visit we spent time observing how staff provided care for people to help us better understand their experiences of the care they received. We spoke with eight people who lived in the home, two visiting relatives, the registered manager, two members of the nursing and care staff team, one member of the activities team, a member of the catering team and the provider's area manager. We also spoke with two local healthcare professionals who had regular contact with the home.

We looked at a range of documents and written records including five people's care records and staff recruitment and training records. We also looked at information relating to the administration of medicines and the auditing and monitoring of service provision.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe living in the home and that staff treated them well. For example, one person said, "I am very safe here. [The staff] support me and give me everything I need." Another person's relative told us, "I think it is safe in here … at home … she kept falling."

People we spoke with had mixed views about staffing levels in the home. Some people told us that the provider employed sufficient staff to meet their care and support needs in a timely way. For example, one person said, "If I call the buzzer they come very quick." However, other people told us of their dissatisfaction. One person said, "There are not enough staff. You have to wait sometimes." Another person said, "They can be very overworked and not have enough time to spend with people." Some people were particularly critical of the lunchtime staffing arrangements. For example, one person who preferred to eat in their bedroom told us they had to wait a long time for meals on occasion, as the staff had to "sort everyone else out first." Another person who chose to eat in the dining room told us, "I have to wait a long time for food. I get called in for lunch at 12 noon and I didn't get served the other day until 1.10pm … as they have to bring everybody in. It's a long time to sit and wait." Reflecting this feedback, on the day of our inspection, we saw that some people waited for 45 minutes for their meal to be served to them in the dining room.

The registered manager told us she kept staffing levels under regular review and had recently increased the number of care staff at night to reflect people's changing needs. However, in the light of people's feedback, further action was required to improve the deployment of daytime staffing resources to ensure people's needs and expectations were met consistently.

We also identified shortfalls in the provider's assessment and management of some potential risks to people's health and safety. For example, in the management of room sharing arrangements. The registered manager told us that the provider was in the process of phasing out the use of shared rooms in the home but, at the time of our inspection, there were still three twin occupancy bedrooms in use, some of which were occupied by people living with dementia. However, when we looked at these people's care records there was no evidence of any formal assessment having been undertaken to identify and mitigate any potential risks to people's safety and welfare arising from these arrangements. We discussed our concerns in this area with the registered manager who told us that she would take steps to ensure the necessary improvement was made.

As a further example of the provider's failure to consistently manage potential risks to people's safety, on the morning of our inspection we observed staff interacting with a person who was living with diabetes. We were advised that this person was exercising strict dietary control in response to medical advice they had received. During the morning tea service, one member of staff correctly advised the person that they were unable to have biscuits with their drink. However, shortly afterwards another, newly recruited staff member gave the person two biscuits, despite the person themselves querying whether this was advisable. We alerted another member of the care team who intervened to ensure no harm was done. However, in the light of this incident, action was required to ensure all staff were made fully aware of potential risks in respect of the people they were supporting.

More positively, other potential risks to people's safety were managed more effectively. For example, the day before our inspection the provider had organised an event in the home to celebrate the fact that no one living in the home had developed a pressure ulcer in the last year. The registered manager told us that staff had worked together in a coordinated way to achieve this milestone. She said she had also recently started to focus on falls prevention in the same way and told us with pride that, in two out of the three months preceding our inspection, there had been no recorded falls in the home. As part of this falls prevention initiative, wireless calls bells had been installed in the home to enable people to request assistance without having to get up to press a call bell.

We reviewed the arrangements for the storage, administration and disposal of people's medicines and found these were in line with good practice and national guidance. Each person's medicines administration record (MAR) contained a photograph of the person to aid identification and a record of any allergies. We observed a medicines round and saw that before giving each person their medicines, the staff member checked the details on their MAR and stayed with the person until they had taken their medicines. Where people received medicines through skin patches, a record of the application site was maintained to ensure the site was rotated in line with good practice. We found some gaps in the signature record on some people's MARs although we were satisfied that the people concerned had received their medicines as required. The provider was aware of the importance of maintaining the MARs correctly and described the systems that were used to follow up any discrepancies identified. The medicines policy and a 'homely remedies' policy were easily accessible to staff in the MARs folder.

Processes were in place for the regular ordering and supply of medicines. Staff told us the local pharmacy was very responsive and any urgently required medicines were supplied quickly. The use of 'controlled drugs' (medicines which are subject to special storage requirements) was managed safely. Staff responsible for administering people's medicines received annual competency checks and refresher training.

Staff were clear about to whom they would report any concerns relating to people's welfare and were confident that any allegations would be investigated fully by the provider. Staff had received training in this area and policies and procedures were in place to provide them with additional guidance if necessary. Staff told us that, where required, they would escalate concerns to external organisations. This included the local authority and the CQC.

The provider had safe recruitment processes in place. We reviewed two staff personnel files and noted that suitable references had been obtained. Disclosure and Barring Service (DBS) checks had also been carried out to ensure that the provider had employed people who were suitable to work with the people who lived in the home.

Good

Is the service effective?

Our findings

People told us they felt well-cared for by staff who had the knowledge and skills to meet their needs effectively. For example, one person said, "They cater for all my needs." Talking positively of the care provided to one person who had recently moved into the home, a local healthcare professional told us, "I didn't recognise [name] the last time I visited the home. I used to see him at home but he looks like a different person now. He has put on weight and was looking so well."

Staff demonstrated an awareness of the principles of the Mental Capacity Act 2005 (MCA). The 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. Staff understood the importance of obtaining consent before providing care or support. For example, one staff member told us, "It's important to make sure they have choice and [not] make decisions for them. For instance, asking people what they would like to wear. Not just putting any old thing on."

The registered manager told us that she and other senior staff in the home made use of best interests decision-making processes to support people who had lost capacity to make some decisions for themselves. Although we were satisfied that any best interests decisions had been taken correctly in line with the provisions of the MCA, we found some aspects of the provider's record-keeping area unhelpful in confirming precisely what best interests decisions were currently in place for each person. We discussed this issue with the registered manager and the provider's area manager who welcomed our feedback and agreed to give the issue early review.

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). At the time of our inspection the provider had submitted 10 DoLS applications and was waiting for them to be assessed by the local authority.

New staff completed a structured induction programme before they started to work as a full member of the team. Reflecting on their own induction, one member of staff told us, "I shadowed [colleagues] for four days. [They] showed me exactly what to do. [And] if you're not sure, you just have to ask." The provider had embraced the National Care Certificate and newly recruited staff worked towards this qualification as part of their induction.

The provider maintained a record of each staff member's training requirements and organised an annual programme of courses to meet their needs including safeguarding and moving and handling. Staff spoke positively of the training they received, for example one staff member said, "I really enjoyed the person-centred planning training … last week. It made me reflect … and helped me validate my own approach." The provider also supported staff to study for advanced qualifications. One member of staff said, "They encourage staff to do NVQ's. Very much so. [Name] is doing Level 2 and they keeping saying [I should] do

Level 5. If you want to progress they will support you."

Staff received regular supervision from senior staff which they told us they found beneficial in further enhancing their skills and knowledge. Talking positively of their experience of supervision, one staff member told us, "We get it all the time. It helps me reflect on my practice. Supervisions really help me." Speaking specifically of the support and supervision they received from the registered manager, another member of staff said, "[The registered manager] is very supportive. If you need to speak to her she will take time out and listen to you."

People told us they enjoyed the food provided in the home. For example, one person said, "The food is good, you get a choice and it's nice and hot. I used to be a chef and I think it's good." Another person told us, "We get plenty of food and drink in the day and evening." People had a range of hot and cold choices for breakfast and also at teatime, including homemade cakes. On the day of our inspection, the chef manager told us she would be making a coconut sponge. For lunch, people had a choice of two main course options except on Wednesday and Sunday when a roast was served. However the chef manager told us that kitchen staff were always happy to make an alternative for anyone who didn't fancy the roast, including one person who often requested an omelette or baked potato instead. Confirming the provider's flexible approach, one person said, "I've never had to refuse either choice [at lunchtime] but …. they would give an alternative if you requested it."

The core menu was prepared nationally in discussion between the provider and the catering company that operated in all of its homes. However, staff in the Red House told us they had a good knowledge of people's likes and dislikes and used this to guide them in their local menu planning and meal preparation. For example, discussing the Spring menu that had just been issued, the chef manager said, "The new menu said chicken thighs in a BBQ sauce. [But] I know the residents [and] we have chicken breast here [as] the residents don't like [thighs]." Talking of one person's particular preferences, the chef manager also told us, "A lot of people don't like pasta … so we don't have a lot of pasta on [our] menu. But [name] likes macaroni cheese so every so often I do it specially for him." Staff also had a good understanding of people's nutritional requirements, for example people who had allergies or who needed their food pureed to reduce the risk of choking.

In preparation for our inspection visit, we noted that the local environmental health inspectorate had raised some minor concerns about the layout of the kitchen, following their last inspection of the premises in July 2016. We discussed this issue with the chef manager who told us that immediate action had been taken to address some of the issues and, in the longer term, plans were in place for a full refurbishment of the kitchen.

The provider ensured people had the support of local health and social care services whenever this was necessary. From talking to people and looking at their care plans, we could see that their healthcare needs were monitored and supported through the involvement of a range of professionals including GPs, district nurses and physiotherapists. Staff told us they would not hesitate to obtain specialist advice and support if they had any worries or concerns about a person's health. Confirming this proactive approach, one person told us, "They call the GP and she comes out." Describing their experience of working with the staff team, a local healthcare professional told us, "We are always made very welcome [and] they are proactive in getting in touch. They act on things pretty quickly."

Requires Improvement

Is the service caring?

Our findings

Staff told us that they understood the importance of supporting people in ways that helped maintain their privacy and dignity. However, during our inspection we found that this was not reflected consistently in their practice. For example, when talking to our inspector, some staff described people in very undignified and impersonal ways as "feeds" (people who needed support to eat) or "soft feeds" (people at risk of choking). On one occasion, in an open corridor where they could have been heard by people living in the home, one member of staff asked a passing colleague if she was "alright feeding one in the dining room". In one person's care file, we found an entry which stated, "May require feeding at times." When we discussed our concerns about the use of this old-fashioned, institutional terminology with the registered manager she acknowledged that improvement was required and told us she would address it as an early training need for staff.

On the morning of our inspection, we also noticed that the home's regular hairdresser was washing and cutting several people's hair in one person's bedroom. A long-serving member of staff told us this arrangement had been in place for several years. When we raised our concerns with the registered manager, she said that the person had given permission for their room to be used in this way, pending the development of a designated hairdressing salon in the home. However, she acknowledged that this use of the person's private, personal space could not continue and told us she would make immediate arrangements for the hairdresser to see people in another part of the home.

More positively, everyone we spoke with told us that staff were caring. For example, one person said, "They are so kind here. And really helpful." Reflecting this feedback, throughout our inspection we saw that staff supported people with in a kind and patient way. For example, on the morning of our visit one person became very upset. In response, we observed a member of staff gently putting an arm round the person and taking time to listen to their concerns. They also responded to the person's request to sit alone in the dining room at lunchtime. Talking about her job, one member of the care staff team told us, "I just love it. I can't explain why. No matter what is going on at home, I come here and smile and laugh with the residents." Describing the caring, attentive approach of staff, one person said, "You only have to ask for something and they will get it for you."

Staff knew people as individuals and reflected this in the way they worked. For example, describing her approach to supporting people to eat, one member of staff told us, "Some people want their food chopped up [so they can eat it themselves] and maintain their dignity. But some residents are very proud and don't want their food cut up. [But if I see them struggling] I just whisper, 'Would you like a hand?'." Talking of one person they supported, another member of staff said, "[Name] was getting anxious about his morning routine [but] we have changed the timing of his breakfast and now he is much more relaxed." Confirming this responsive, person-centred approach by staff, this person told us, "We've been trying a new routine. It's working really well."

Staff also understood the importance of helping people to maintain their independence and to exercise control over their lives wherever possible. For example, talking of their approach to the provision of personal

care, one member of staff said, "It's so easy to give up and have someone do it for you [but] they need to be as independent as possible. It keeps the mind active. I encourage people to put their own socks on or do their own buttons up. I half do them for some people." Discussing the importance of respecting people's right to make their own choices and decisions, another member of staff told us, "When [I am helping people get dressed], I ask people what they would like to wear. [I don't] just put any old thing on. It's the same with food." Reflecting this approach, one person said, "They give you choices and ask you questions so you can decide."

Information on local lay advocacy services was available to people living in the home. Lay advocacy services are independent of the service and the local authority and can support people to make and communicate their wishes. The registered manager told us no one living in the home had the support of a lay advocate currently but that staff would help someone obtain one, should this be necessary in the future.

Requires Improvement

Is the service responsive?

Our findings

The provider had recently appointed two new activities coordinators to take the lead in facilitating the provision of communal activities and other forms of stimulation for the people living in the home. At the time of our inspection, the lead coordinator had been in post for one week and her assistant for two days. Prior to these very recent appointments, the home had been without a designated activities coordinator for almost six months. Although the provider told us that temporary arrangements had been in place during this period, some of the people we spoke with expressed their dissatisfaction with the amount of stimulation and occupation available to them. For example, one person said, "I would like to get out but we don't." Describing their feelings of loneliness, another person who spent the majority of their time in their bedroom, told us, "There are no one-on-one activities [that] I would be able to participate in." The new lead coordinator told us, "We've not had a permanent activities coordinator [since October 2016]. It's not an ideal situation. [Because people] have not had a great deal to do, it's hard to get them interested again."

Despite the recent appointments to the activities team, we found a confused, unstructured approach towards the provision of activities and other events. For example, the registered manager told us that there was a monthly activities programme in place for April 2017. However, when we looked at this programme we found it was for one of the provider's other homes and described events that would be taking place there, not at The Red House. Similarly, the registered manager told us that there was an annual programme of planned events for the home but when we reviewed this document we found it was simply a list of national holidays such as Christmas Day and Easter Sunday and some national events including the Chelsea Flower Show and national Carers' week, which were of little direct relevance to the people living in the home. We saw that a local theatre company was booked to visit the home to give a show, although the poster advertising this was in a part of the home that was not accessible to most people. Reflecting the fact that she had only been in post for a week, the lead activities coordinator had not yet had the opportunity to develop a programme of regular events, although she had been able to facilitate some unplanned activities. However, describing the shortcomings in this approach she told us, "I have just been doing things on a spontaneous basis [but] it's better for people to [be able to] plan ahead. If they knew in advance what's happening they can choose whether to join in or not. It increases their independence."

On the day of our inspection, we saw that some unplanned activities did take place which provided a degree of stimulation for some people. However, at other times we saw people sitting for extended periods with little or nothing to do and only occasional interactions with passing staff. Although the appointment of the new activities team was a positive step, it was clear that further action was required to ensure people living in the home were provided with sufficient stimulation and occupation to meet their individual needs and preferences.

If someone was thinking of moving into the home, the registered manager normally visited them personally to carry out a pre-admission assessment to make sure the provider could meet the person's needs. Once it was agreed that someone would move into the home, an admission date was agreed with the person and their family. Talking of the importance of managing this process as sensitively as possible, the registered manager said, "We don't like admissions in the afternoon as [if there is any delay] it can get late and the

person can become very tired." Once the person had moved in, senior staff used the pre-admission assessment to provide care staff with initial information on the person's key preferences and requirements, pending the development of a full individual care plan.

We reviewed people's care plans and saw that they were well-organised and provided staff with the information they needed to respond to each person's individual needs and preferences. For example, one person's plan contained detailed guidance for staff on how to support the person to manage a long-term health condition. Another person's plan stated that they enjoyed fish and chips and liked to dress smartly at all times. However, we found that staff did not always use the information in the care plans to support people in a responsive, person-centred way. For example, one person was registered blind. To enable them to retain as much independence as possible, this person's 'eating and drinking' care plan stated they should be provided with a special plate and bowl and their food should be cut up. However, at lunchtime we observed the person's meal was served on the same crockery as everyone else's and, initially when their plate was left with them, their food was not cut up.

More positively, the provider had a systematic approach to ensuring staff reviewed the care plans on a regular basis, in discussion with people and their relatives if they wanted this level of involvement. Talking of a recent care plan review meeting, one person told us, "I had a review the other day and it went okay."

Information on how to raise a concern or complaint was provided in the information pack people received when they first moved into the home. The registered manager told us that formal complaints were rare as she encouraged people and their relatives to alert her or other staff to any issues or concerns, to enable them to be resolved informally. Confirming the registered manager's approach in this area, one relative said, "I have no complaints but would happily speak to the manager if I should need to." When formal complaints were received we saw that the registered manager had ensured these were handled correctly in accordance with the provider's policy.

Good

Is the service well-led?

Our findings

There was a comfortable, relaxed atmosphere in the home and most people we spoke with told us they were happy with the service provided. For example, one person said, "It's like home from home." Another person's relative told us, "[Name] has a good relationship with staff. They give her everything she needs." However, discussing the concerns about staffing outlined elsewhere in this report, one person said, "I couldn't recommend it."

Throughout our inspection, the registered manager demonstrated an open and responsive leadership style. She was also quick to acknowledge some of the shortfalls we identified during our inspection, including those relating to room sharing and the use of institutional terminology by staff. The registered manager had been post for about a year and in this time had clearly won the loyalty and respect of her staff team. For example, one member of staff told us, "[Name] is an absolutely brilliant manager. She wants the home to be a success and she wants us to be doing the right things." Another staff member said, "[The registered manager] is lovely. A no-nonsense manager [but] very fair [and] very supportive. She is always downstairs and is very happy to help out on care." Reflecting this feedback, during our inspection we saw that the registered manager regularly took time out of her office to circulate in the home, talking to people and providing her colleagues with additional hands-on support if needed. To further increase her accessibility and visibility, the registered manager told us she was in the process of moving her office downstairs from its current attic location.

Staff worked together in a friendly and supportive way. One member of staff told us, "It's a lovely place to work. I love the happiness and the home has a nice ambiance." Regular team meetings, daily logs and shift handover meetings were all used by the provider to ensure effective communication between staff. Talking positively about their experience of attending team meetings, one staff member said, "We have them once a month. It lets us know where we are with any changes. Things that [the registered manager] doesn't want us to do. A lot has changed … in the last year … I think it will be for the better." The provider's area manager was present throughout our inspection and staff told us that she was a regular visitor to the home. Speaking positively of the area manager's approach, one staff member said, "[Name] is always floating about. She is very approachable and always says hello staff and residents."

The provider was aware of the need to notify CQC or other agencies of any untoward incidents or events within the service. We saw that any incidents that had occurred had been managed correctly in consultation with other agencies whenever this was necessary. The registered manager told us that she took time to reflect on significant events to identify any learning for the future. For example, in response to a recent issue she had made changes to the way she handled new admissions to the home.

The provider had a range of audits in place to monitor the quality of care. The provider also conducted an annual survey of people and their relatives to measure their satisfaction with the service provided. At the time of our inspection, the registered manager was waiting for the results of the most recent survey but told us she would review these carefully to see if any improvements were required. The registered manager also organised regular meetings with the people who lived in the home, to seek people's opinions and update

them on any changes. We reviewed the minutes of the most recent meeting and saw that there had been a positive and interactive discussion on a range of topics including food and activities.

There were also regular meetings with people's relatives, although the registered manager told us she was currently evaluating the format of these meetings to try to increase attendance. She told us that she had invited the provider's head of dementia to give a talk at one recent meeting. This had proved particularly popular and, as a result, she was considering inviting guest speakers to future meetings.