HICA

Red House - Care Home

Inspection report

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Ratings

Overall rating for this service	Requires improvement
Is the service safe?	Requires improvement
Is the service effective?	Requires improvement
Is the service caring?	Requires improvement
Is the service responsive?	Requires improvement
Is the service well-led?	Requires improvement

Overall summary

We carried out this inspection on 8 and 9 October 2015. This inspection was planned to check whether the registered provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

The inspection was unannounced; which meant that the staff and registered provider did not know that we would be visiting.

The last inspection was carried out on 16 April 2014; at that inspection Red House Care home was found to be compliant with the regulations we looked at.

Red House is a care home that is registered to provide care and accommodation for up to 48 older people. The home is divided into two units, 'Burlington' which provides support for people who require residential care and who may have a mild cognitive impairment and 'Bayle' which specialises in support for people with more complex dementia related conditions. On the day of the inspection there were 40 people living at the home which is located in Bridlington, a seaside town in East Yorkshire.

The home is required to have a registered manager in post. On the day of the inspection there was a manager in post who was registered with the registered provider at another location. At the time of the inspection the

Summary of findings

manager had submitted an application to the Care Quality Commission (CQC), to change the location of their registration to Red House. A registered manager is a person who has registered with CQC 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.

We found there were insufficient numbers of staff to effectively meet the needs of the people living in the home during traditionally busy times of the day, including the morning when people required the highest levels of support with personal care and also at mealtimes. This was a breach of a regulation. You can see what action we told the provider to take at the back of the full version of the report.

We found that Mental Capacity Act (MCA) (2005) guidelines had not always been followed. We saw that when decisions were made on people's behalf these a capacity assessment had not always been completed and the decision had not been taken at a best interest meeting. This was a breach of a regulation. You can see what action we told the provider to take at the back of the full version of the report.

We found the registered provider had audits in place to check that the systems at the home were being followed and people were receiving appropriate care and support. However we found that these were not always effective. This was a breach of a regulation. You can see what action we told the provider to take at the back of the full version of the report.

People told us that the staff were caring and they felt well looked after. We saw people were treated with respect and dignity and saw examples of positive interactions between the staff and people living in the home. However, these were too infrequent to provide enough stimuli for people. We made a recommendation regarding the levels and type of interactions between staff and people living in the home.

We found that people were offered some activities and that activity coordinators were employed. However, staff, relatives and people living in the home all told us that there was not enough activities. We have made a recommendation around the homes activity programme.

We found that the recording of some documentation including food, fluid and repositioning charts was inconsistent. We have made a recommendation regarding the homes recording of charts.

People told us they felt safe and we found that people were protected from the risks of harm or abuse because the registered provider had effective systems in place to manage any safeguarding issues. Staff were trained in safeguarding adults from abuse and understood their responsibilities in respect of protecting people from the risk of harm. We found that effective recruitment and selection procedures were in place and appropriate checks had been undertaken before staff began work.

We found assessments of risk had been completed for each person and plans had been put in place. Incidents and accidents in the home were accurately recorded and monitored monthly. The home had a system in place for ordering, administering and disposing of medicines and this helped to ensure that people received their medicines as prescribed.

Some people who used the service were subject to a level of supervision and control that amounted to a deprivation of their liberty; a standard authorisation application for each person had been completed and these were being reviewed by the supervisory body of the local authority. This meant there were adequate systems in place to keep people safe and protect them from unlawful control or restraint.

People's nutritional needs were met. People told us they enjoyed the food, were given a good choice of meals and they received enough to eat and drink. However the meal time experience for people across the home was inconsistent due to insufficient staff numbers.

Staff told us they were well trained. We saw that staff completed an induction process and they had received a wide range of training, which covered courses the home deemed essential, such as safeguarding, moving and handling and infection control and also home specific training such as dementia awareness.

Peoples health needs were met. People were supported to maintain good health and had access to healthcare professionals and services. People were encouraged to have regular health checks and were accompanied by staff or relatives to hospital appointments when necessary.

Summary of findings

We saw that people had an individual plan, detailing the support they needed and how they wanted this to be provided. People had risk assessments in their care files to help minimise risks whilst still supporting people to make choices and decisions.

We found that peoples comments and complaints had not always been responded to appropriately, however since the new manager had been appointed this had improved. We saw that systems were now in place to seek feedback from people and relatives about the service. We saw that any comments, suggestions or complaints were now appropriately actioned.

There was a new manager in post and people told us they were able to approach them with any concerns they may have. People told us they felt the home had improved since their appointment and were confident that the improvements made so far would continue.

Summary of findings

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.

There were insufficient numbers of staff to effectively meet the needs of the people living in the home during busy times of the day.

Staff displayed a good understanding of the different types of abuse and had received training in how to recognise and respond to signs of abuse to keep people safe from harm.

The home had a robust system in place for ordering, administering and disposing of medicines.

We found that effective recruitment and selection procedures were in place and appropriate checks had been undertaken before staff began work.

Is the service effective?

Requires improvement

The service was not always effective.

The Care Quality Commission is required by law to monitor the operation of the Deprivation of Liberty Safeguards. We found the service to be meeting the requirements of the Deprivation of Liberty Safeguards (DoLS).

The home manager showed an understanding of the Mental Capacity Act (MCA) (2005). However we found the guidelines were not always followed.

Peoples nutritionally needs were met. However the meal time experience for people in the home was inconsistent.

People's health needs were met. People who used the service received, where required, additional treatment from healthcare professionals in the community.

Is the service caring?

Requires improvement

The service was not always caring.

We found that levels of interaction between staff and people living in the home were task orientated and did not always promote people's wellbeing.

People were treated with respect and staff were knowledgeable about people's support needs.

People were offered choices about their care, daily routines and food and drink whenever possible.

Is the service responsive?

Requires improvement

The service was not always responsive.

Summary of findings

We found the home employed two activity coordinators and saw that some activities were offered. However people told us that not enough activities took place and that they would welcome further opportunities to go out into the community

Care plans were in place outlining people's care and support needs. These were being reviewed and updated by the manager. Staff were knowledgeable about people's support needs.

People were able to make suggestions and raise concerns or complaints about the service they received. These were listened to and action was taken to address them.

Is the service well-led?

Requires improvement

The service was not always well led.

The manager and registered provider were in the process of introducing more robust quality assurance documentation including audits and risk assessments. However the current system had failed to identify a number of issues found during this inspection.

Recording of information by staff was inconsistent and peoples repositioning charts and food and fluid charts were inaccurately completed.

There was a manager in post who was in the process of moving their registration with the Care Quality Commission from another location. People felt the home was well run and they said they were happy there.

Staff were supported by their manager. There was open communication within the staff team and staff felt comfortable discussing any concerns with their registered manager.

Red House - Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection was carried out on 8 and 9 October 2015 and was unannounced. The inspection team consisted of two Adult Social Care (ACS) inspectors and one Specialist Advisor (SPA). A SPA is someone who can provide specialist advice to ensure that our judgements are informed by up to date clinical and professional knowledge.

Before this inspection we reviewed the information we held about the home, such as notifications we had received from the registered provider and information we had received from the local authorities that commission a service from the home. We also contacted the local authority safeguarding adults and quality monitoring teams to enquire about any recent involvement they had with the home.

The registered provider was not asked to submit a Provider Information Return (PIR) prior to the inspection. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We carried out the inspection at short notice because we had received information of concern that we needed to follow up.

During the inspection we spoke with six people who lived in the home, five visiting relatives, seven members of staff, the catering manager, the administrator and the registered manager. We spent time observing the interaction between people who lived at the home, relatives and staff. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We looked at all areas of the home, including bedrooms (with people's permission) and office accommodation. We also spent time looking at records, which included the care records for four people, handover records, the incident / accident book, supervision and training records of three members of staff, staff rotas, and quality assurance audits and action plans.

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Is the service safe?

Our findings

On the day of the inspection we found the morning shift was covered by the manager, two senior care staff and four care staff. In addition to the care staff we saw there was an activity coordinator and two domestic staff. The home is split into two 'suites', Burlington and Bayle. There were 19 people living in Burlington suite and 21 people living in Bayle suite at the time of this inspection. We saw that each suite had a senior carer and two care staff and additional support was provided at mealtimes by the domestic staff and the activity coordinator.

We found that there were insufficient numbers of staff to effectively meet the needs of the people living in the home during traditionally busy times of the day, including the morning when people required the highest levels of support with personal care and also at mealtimes.

All of the staff we spoke with told us more staff were needed. We spoke with one member of staff in the Bayle suite and they told us that of the 21 people they cared for, five required two carers to support them with moving and handling and four required assistance to eat and drink. They expressed their concern at the lack of staff at busy times and told us "We need to have a member of staff present in the dining room in the morning. If there was a choking incident there would be nobody there to respond." On the day of the inspection we saw that additional support was provided by the activity coordinator who was in the dining room with six people. However we were told that they were not always available to provide this support. However, during our observations of this period of the day we found that if the activity coordinator was required to assist a person with their personal care then this left five people eating in the dining room without supervision.

People who lived in the service told us they felt that more staff were needed. We asked people if they had to wait long for staff to respond and one person told us "Yes, sometimes I have to wait, but that's because there isn't enough staff. I feel sure they could do with more staff." Another said "I think they could do with some more staff. I think one lady in the afternoon would make a difference." People also told us they felt that the number of staff currently deployed limited their opportunity to safely access the local area. One person said "Apart from hospital I have probably only gone out once or twice. The lack of staff doesn't help."

A relative told us they did not feel that there were enough staff on duty to meet the needs of their family member living in the home. They told us of one example when they visited and rang the buzzer for some assistance but nobody came. This meant they had to go and find a member of staff to provide the support they were required and were worried what would happen if they were not present to do this. They told us that this was not an isolated incident and in their experience people often had to wait for assistance. However, they told us that when carers did attend they were generally kind and caring but did not have time to support with more than basic care.

We looked at the results of the recent relative surveys and found that some comments also reflected the need for more staff. The comments included 'I think the home does the best it can but definitely feel it warrants more staff' and 'The care plan states my father will be taken out but there's no staff.'

Our observations support the concerns that had been raised by staff, relatives and people living in the home.

This was a breach of Regulation 18. Staffing, of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We discussed the staffing levels with the manager and told us they felt that at the time of this inspection six care staff were enough to meet the needs of the people living in the home. However, they told us that they would review this arrangement to ensure that people's needs were being met.

People we spoke with told us they felt safe. Comments included "I like living here and I do feel safe" And "I feel safe here. It's clean and people care for me." A relative told us "Oh yes, [Name] is very, very safe."

People knew how to raise concerns and told us they felt confident to approach the care staff, the senior care staff or the manager if they had any worries. One person said "I would speak to most of the carers." Another told us "I would speak to the senior."

Prior to the inspection we had spoken with the East Riding of Yorkshire Council (ERYC) safeguarding team and they informed us they had received eight safeguarding alerts in relation to the home. They told us that one had come directly from the home and that the other alerts had come from other sources. All of these alerts were received prior to

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Is the service safe?

the new manager commencing employment at Red House. We saw that since coming in to post the new manager had retrospectively submitted any outstanding concerns to ensure that both the Care Quality Commission (CQC) and the local safeguarding team had a full understanding of any incidents and issues that had occurred within the home. This showed the new manager recognised the importance of informing the relevant authorities when concerns were raised.

On the first day of the inspection we found that the service had policies and procedures in place to guide staff in safeguarding people from abuse. The manager showed a good knowledge of incident reporting and explained how they used the local authorities safeguarding tool to decide when they needed to inform the safeguarding team of an incident, accident or an allegation of abuse. We saw that safeguarding concerns were recorded, audited weekly and submitted to both the local safeguarding team and the CQC as part of the registered provider's statutory duty to report these types of incidents. Since the inspection took place the CQC have received regular notifications from the home.

The staff we spoke with were knowledgeable about the safeguarding process and they were able to tell us how they would identify abuse and also what steps they would take if they felt they had witnessed abuse. They said that they understood the need to report incidents and felt that they could speak with the manager directly. They also knew how to escalate any concerns should there worries not be appropriately addressed.

We checked the homes training records and found that all staff had received Safeguarding vulnerable adults training within the last 12 months. The manager also told us they planned to meet with staff to ensure they had a thorough understanding of their responsibilities regarding incident reporting.

We saw the home had systems in place to ensure that risks were minimised. Care plans contained risk assessments that were individual to each person's specific needs. This included an assessment of risk for falls, pressure care, mobility, nutritional status. We saw Personal Emergency Evacuation Plans (PEEP) for all of the people living at the service. The purpose of a PEEP is to provide staff and emergency workers with the necessary information to evacuate people who cannot safely get themselves out of a building unaided during an emergency. We also saw that incidents and accidents were accurately recorded and audited on a monthly basis. This meant that risks were continually monitored, enabling the manager and staff to take appropriate action.

We looked at the recruitment records for three staff members. We found the recruitment process was robust and all employment checks had been completed. Application forms were completed, references obtained and checks made with the disclosure and barring service (DBS). The DBS carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This helps employers make safer recruiting decisions and ensured that people who used the service were not exposed to staff that were barred from working with vulnerable adults. Interviews were carried out and staff were provided with job descriptions and terms and conditions. This helped to ensure staff knew what was expected of them.

We found that there were appropriate arrangements in place for obtaining medicines; checking these on receipt into the home; and storing them. Adequate stocks of medicines were securely maintained to allow continuity of treatment. The medicines trolley was stored safely and at the correct temperatures.

People told us they were receiving their medication at the right time. One person said "Staff give me it in the morning. There's a certain time they issue medicines." We saw that people were receiving their medicine as prescribed by their doctor. Any medicines which had been administered were recorded on their medication administration records (MARs). Any medicines which had not been administered were signed for by staff to acknowledge why this had not been given. The application of prescribed topical creams/ ointments was clearly recorded on a body map, showing the area affected and the type prescribed. We saw that if a medicine was refused then it was bagged up individually and placed with the returns medicine. This ensured that medicine was disposed of in line with the homes policy and procedures.

We did note that topical medicines did not always have a date to identify when they had been opened and when they would expire. We also found there was not a designated frequency for stock checking 'as required' (PRN) medications; However, the PRN medications we checked tallied with the amount recorded showing that the system

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Is the service safe?

in place was effective. We discussed this with the manager who told us they would address this through supervision and ensure that all stocks checks were completed within a regular time frame.

We found the home to be clean and tidy and free from odour in the Burlington suite although we noted a slight odour on arrival in the Bayle suite. We discussed this with the manager and they informed us the source of the odour was the carpets and they had plans to replace them with a more suitable non slip, easy to clean flooring once funding has been approved. It was hoped that this would enable more effective cleaning and in turn reduce or remove any malodour present.

We saw that personal protective equipment (PPE) was available around the home and it was evident staff knew when they needed to use this. We spoke with the housekeeper who told us they were able to get all the equipment they needed. They said "Since the new manager has come in we get more cleaning materials, they got new bedding for everyone and they are also getting us new mops and buckets."

Visitors to the home told us that the homes environment had improved since the new manager had come in to post. The manager told us that they had implemented a number or improvements to the homes environment and this had included new bedding, new flooring in the medication room and the introduction of a more detailed cleaning rota to ensure that equipment including wheelchairs and hoists were regularly cleaned and that deep cleaning of problematic areas took place. The manager told us they had further developments planned.

The home had achieved a rating of 5 following a food hygiene inspection undertaken by the local authority Environmental Health Department. The inspection checked hygiene standards and food safety in the home's kitchen. Five is the highest score available.

Requires improvement

Is the service effective?

Our findings

The Care Quality Commission monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care services. DoLS are part of the Mental Capacity Act 2005 (MCA) legislation which is designed to ensure that the human rights of people who may lack capacity to make decisions are protected.

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 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. We saw five people using the service were subject to a DoLS authorisation and the service had made a total of 12 applications to the local authority.

We saw one person's care plan stated 'all medication now delivered covertly'. Covert administration of medicines is only used when medication needs to be given in a disguised format, for example in food or a drink, without the knowledge of the individual and only when the decision to administer medication in this manner, has been discussed and agreed with those involved in their care and has been deemed in their best interests. However, there was nothing recorded in the persons care plan to indicate they had been consulted regarding this decision and whether a capacity assessment had been completed and a best interest meeting held. Best interest meetings are held when people do not have capacity to make important decisions for themselves; health and social care professionals and other people who are involved in the person's care meet to make a decision on the person's behalf. There was no information to indicate in what form the medication was administered. This showed that the service was not working within the principles of the MCA.

This was a breach of Regulation 11. Need for consent, of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We discussed this with the manager who confirmed that this arrangement had been put in place prior to them coming into post. The manager had a clear understanding of when they would arrange best interest meetings. They showed us an example of the paperwork they intended to use to record these decisions in the future.

We discussed the use of restraint with the manager and were told that the home did not use restraint practices with any of the people living at the home; the staff we spoke with supported this. The manager told us that one person had a history of refusing personal care and minor restraint had been considered, however, the manager was unsure how often the care staff offered to provide personal care to the person. The manager had put monitoring charts in place to record when it was offered and found that this simple prompt meant that the person now received regular personal care without issue. This meant the manager explored the least restrictive option to ensure that people's personal care needs had been met.

People we spoke with told us they enjoyed the food and that there was enough to eat. They told us, "The foods good and served warm. We get two dishes and they are properly seasoned, I would say if it wasn't OK." Another said "Oh yes I get enough, I don't eat and drink much but I get enough." And, another said "I get too much; I should tell them if I didn't." A relative told us "The food is fantastic, I have eaten here myself, they can have a cooked breakfast, lunch at 12 and an evening meal at 5pm."

We found that people living in the home were offered a good choice of food at breakfast time. On our arrival we saw that people had the choice of a full cooked breakfast, bacon and egg sandwiches, beans on toast and eggs on toast. In addition to this a choice of cereals and toast were available. We heard the staff asking people how many slices of toast they wanted, whether they wanted white or brown bread and saw they were offered a choice of tea or coffee.

We observed mealtimes in both the Bayle and Burlington suites. We saw that the lunchtime experience for people living in the home was inconsistent. We observed the serving of lunch in the Bayle suite and we saw that tables were set with tablecloths, placemats, cutlery and

condiments on each table. Almost half of the people (10) chose to eat in the dining room and were supported by the activity coordinator and a member of the domestic staff. None of the people in the lounge required help with eating and drinking. Other people preferred to eat in private, either in their own room or in one of the lounge areas. Four of these people required help with eating and drinking and we saw this was provided by the three care staff.

We saw that the food looked appetising and we could see steam coming from it indicating it was hot. A choice of orange or blackcurrant juice was offered. We saw that one person who had not eaten any of their lunch was offered a choice of sandwiches as an alternative.

We found that there was no menu board on display. We spoke with a member of staff and were told that the board had been taken down when the home was redecorated and had not yet been replaced. We also noticed that people were not told what the meal was when it was presented to them and that there was little conversation happening either amongst the people who lived in the home or with the staff. This meant that people may not know what was on the menu and that a social opportunity may be missed as mealtimes were not being utilised as well as they could be.

We observed the serving of lunch in the Burlington suite. The tables were set and people had a choice of food and drink. We saw that 14 people chose to eat in the dining room and one of them required help with eating and drinking and others required prompting and / or encouragement. We found that there was insufficient staff to meet everybody's needs as only two members of staff were present; one was serving the meals and the other encouraging several people to eat, whilst also providing support for one person who required full assistance with eating and drinking. This was clearly very stressful for the staff member involved and negatively affected the dining experience for people in the room. It also meant that it took much longer than is acceptable for the person requiring assistance to receive their food meaning it could become cold and unappetising.

We discussed this with the manager and they informed us that the registered provider had recognised that the dining experience required improving and they had carried out a review of the dining experience across all of their homes. The catering manager provided us with a comprehensive report on how they were planning to improve the 'dining experience' for the people living in the home. However, the manager told us they would assess what they could do in the short term to improve the experience for people living in the home.

We saw the home used the Malnutrition Universal Screening Tool (MUST) to help assess people's nutritional needs and determine what 'plan' a person should be on in relation to their current weight and body mass index (BMI). The MUST is also used to inform the staff when a referral to the GP or dietitian is necessary to fully assess a person's nutritional status. The manager told us that people were weighed monthly unless they were deemed to be nutritionally at risk, in which case they were then weighed weekly. We saw that people's weights were recorded in their care plans and if a weight loss was indicated we saw that people were referred to the GP or dietitian for a full nutritional assessment.

Care staff received a three day induction which took place at the registered providers head office. This covered a variety of training topics ranging from practical guidance in moving and handling right through to the basics of correctly setting a table at mealtimes. The manager told us that from 12 October 2015, on the completion of their induction, all new staff will be required to complete the Care Certificate over a 12 week period. The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working life.

We looked at the homes training records and saw that staff had completed training in safeguarding vulnerable adults, moving and handling, fire training, infection control, food hygiene, health and safety and challenging behaviour. We also saw that a high percentage of staff had also completed additional training in pressure care, care of the dying, dementia awareness, dementia and toileting, Malnutrition Universal Screening Tool (MUST), data protection, dysphasia and modified diets and the Mental Capacity Act (MCA) 2005. This training supported staff to gain the necessary skills and knowledge to effectively care for people living in the home.

We could see from the training records that all of the staff received the same training irrespective of what their role in the home was, although the domestic staff and activity coordinators also completed specialist training to enable

Requires improvement

Is the service effective?

them to safely and effectively carry out their role. This meant that the whole staff team had the skills and knowledge to be able to support people in a variety of ways.

The staff we spoke with told us they received supervision either from a senior care worker or from the manager. Supervision is a process, usually a meeting, by which an organisation provides guidance and support to staff. It is important staff receive regular supervision as this provides an opportunity to discuss people's care needs, identify any training or development opportunities for staff and to address any concerns or issues regarding practice. The manager provided us with a 'Staff supervision responsibilities' document that outlined which members of staff the senior care staff were responsible for supervising. The manager told us that all the seniors had received coaching on how to effectively supervise people.

Peoples health needs were supported and were kept under review. One relative told us "They contact the GP when they need to; [Name] is on antibiotics at the moment." They also said "[Name] is on a special liquid diet at the moment, they have fortisip and forticreme" and "They got a dietitian involved and have done everything they need to." We saw from care records that people had detailed information recorded regarding their health and that other professionals were involved in people's care for example their GP, social worker, psychiatrist or dietician.

We spoke with one health and social care professional who had visited the home on a regular basis, they told us "I have noticed a tangible difference in the home since the new manager was appointed. In the last month communication has improved and there has been much more contact between the home manager and the team."

The home was decorated to a good standard and the registered provider had started the process of moving towards a more dementia friendly environment. We saw that the bedroom doors had been painted in bright colours with numbers and there were signs on other doors to identify bathing and toilet facilities. We also saw that there was a small room which was designated as a reminiscence area. However, we found that signage was lacking from corridors and additional consideration could be given to lighting, colour, reflective surfaces and décor. We discussed this with the manager and they told us that they had plans to upgrade the home to make it 'dementia friendly' and more suited to people living there.

We found that people were able to personalise their rooms with items of furniture, photographs, pictures, ornaments and other personal affects. The manager told us that people were offered a choice of colour for the walls of their rooms and their bedding to further personalise their own space.

Requires improvement

Is the service caring?

Our findings

People living in the home told us that they felt that they were well looked after and that the staff were caring. Comments included "They are ever so good to you", "They are lovely these girls", "Carers are nice", "They respect me and we have good fun" and "They are nice girls. They are very, very kind."

We asked one person what they thought about the care they received. They told us "It's good. I think the staff do more than they should for what they are paid" and "Nothing is too much trouble for them." When asked if the staff were caring people told us "I'm pampered, I get cleaned and I get plenty to eat." And "We are kept clean and that makes a big difference. I like to be clean."

However, some of the people we spoke with told us that the attitude of the staff was not always a positive one. One person told us that in the past staff had been quite rude; however, they stated that staff attitude had recently improved. We discussed this with the manager. They told us that this issue had been brought to their attention and they were addressing it. They told us that morale had been low amongst the staff group and they hoped as this improved then so would some of the staff's attitude towards the important role they carry out. During this inspection all of the staff we spoke with displayed a positive attitude.

We carried out observations to look at how staff engaged with people living at the home and to see if people were experiencing positive and meaningful interactions from staff which enhanced their wellbeing. We found that care was very task based, for example, support with eating, drinking or taking medication. When tasks such as these were not being completed we found there was little to occupy people's time.

We spoke with the manager who showed good knowledge around the importance of positive staff interactions on people's well-being and the need for people to be occupied in meaningful activities. They told us that this issue had been addressed in supervision and we saw evidence of this. However, our findings during the inspection indicated that this has not yet been fully resolved.

When staff did engage with people living in the home they spoke to them in a friendly manner and showed them kindness and respect. We saw they knew how to engage with people in different ways. They knew who they could laugh and share a joke with and also who they needed to communicate with in a more formal way. One person living in the home told us "Sometimes I get a bit grumpy and the carers put me right and I know what to regard and disregard, they are always fair." Relatives told us "Some of the staff like to have a bit of banter with [Name], but it is all appropriate" and "The staff seem to care, [Name] never complains and always smiles when they see the carers."

Staff told us they wanted to spend more time with people, chatting and engaging them in one to one activities to make them feel important, but did not always have the time to do so. However, we saw that there were missed opportunities to engage with people, such as taking the time to say hello and ask how people were when passing them in different locations in the home.

Some people felt they were listened to and that they could clearly influence how their care was provided. They told us "Yes I'm cared for, If I want something they get it for me" and "Oh yes, they listen to what you've been doing, they're grand." However, others felt they had less say over how their care was delivered stating "I have very, very little say over my care." We discussed this with the manager and they told us they would talk to the person directly to discuss how this could be improved.

We saw that people were given some choice about how their care was delivered. We saw that people were able to get up when they wanted and could go to bed at a time of their choosing. At mealtimes people were offered a choice of food and could decide where they wanted to eat their meal. We also saw that a hairdresser visited the home twice a week. We observed one person being asked if they wanted their hair cutting today, and we saw that they chose to have this done.

We saw that staff knocked on peoples door before entering and they informed people what they were going to do before carrying out any caring intervention such a supporting with moving and handling or assisting people to go to the toilet. We saw that some of the staff had pride in their role and wanted to make the home as nice as they could for the people living there. A member of domestic staff told us "I wouldn't let my mum sleep in a dirty bed and I won't let any of the people here have to either."

The manager was concerned to find that people living in the Bayle suite had been provided with plastic plates,

Requires improvement

Is the service caring?

bowls and cutlery at mealtimes and felt this was not appropriate. They told us that they had purchased new crockery which was in the office on the day of the inspection. We saw photographs had been taken to place in the dining room so all staff were aware of what crockery and cutlery should be provided for people at mealtimes. This showed that the manager treated people with dignity.

Relatives were welcome to come and go as they pleased although they were discouraged from visiting people in the dining room during mealtimes. We saw that people could choose to eat with their family in other areas during this time if they wished. We saw that one person's spouse spent long periods of time in the home with their partner and assisted them with meals and provided them company. One relative told us "We are always made to feel welcome."

We recommend the home continues to take measures to improve staffs awareness of the need for regular and positive interactions with people living in the home.

Requires improvement

Is the service responsive?

Our findings

As part of the admission process people had all aspects of their life assessed to ensure the home was able to meet the needs of the person. As the manager had only been in post for a short period of time they had not yet completed a pre admission assessment. However, they told us that they would carry out this assessment themselves to ensure they were fully aware of what was required to meet the care and support needs of the person and to assess any impact this could have on staffing levels.

We saw that the information gathered during this initial 'focus' assessment was used to determine people's dependency levels and more detailed care and support plans and risk assessments were then developed. This included, for example, information on a person's mobility, nutritional needs, personal care and medicines.

Care files included patient passports and lifestyle profiles which described in detail the person's normal daily routines, such as what time people usually liked to be woken up, what they liked for breakfast and whether they woke throughout the night. Patient passports explained how to care for people should they be admitted to hospital. These included key information regarding whether the person had any allergies or any habits that would enable the hospital staff to provide more personalised care.

We saw that some of the people who lived in the home and their relatives had been involved in the planning of their care and preferences including hobbies, food and drink, likes and dislikes had been considered. One relative told us "[Name] and I were both involved in the care plan. We looked at what was required and if [Name] agreed with it." They also said "About four weeks ago they reviewed the care plan and I was involved." One person who lived in the home told us "We did a care plan but that was a long time ago. Although I did sign something earlier this year."

We did note that some of the care plans required updating and we saw one person's essential lifestyle plan did not reflect their current circumstances. The manager explained they were still in the process of reviewing and where necessary updating care plans to ensure they were reflective of the person's needs. They told us they intended to have this fully completed by the end of October 2015.

The home employed two activity coordinators who provided a mixture of group and individual activities seven days per week. We spent time talking with the activity coordinator who was present on the day of the inspection. We watched them carry out an 'Oomph' activity with four people, this involved doing seated exercises. We saw people laughing, smiling and taking part with enthusiasm indicating this was an activity that people enjoyed.

The activity coordinator showed us the activity area and we saw there were lots of books, games, DVD's, CD's, and maps available. There were also twiddle muffs and rummage boxes available for people to pick up and interact with to help alleviate anxiety and provide them with interesting items to explore. Entertainers were invited into the home and this included the Frantic theatre, a vintage singer and other events were also arranged including a summer fayre, Christmas pantomime, bonfire night and a dog show. The activity coordinator told us they had taken people out of the home on a one to one basis to enable them to complete their own shopping or simply to go to a local café and have a drink in a different environment.

They told us they had made requests in the past for more dementia friendly activities and had suggested changes to the environment but had not received the funding to implement this. However, since the new manager had arrived they had received an activity budget which had enabled them to purchase some new activities for the home. They told us that they had completed activity specific training including a two day 'oomph' course that enabled them to deliver exercise and group activities that encouraged people to move around and be as active as they can. They were clearly passionate about their role in the team and they told us "I'm lucky in my role as I get to spend quality time with every resident."

People in the home told us that they didn't feel there were enough activities taking place. One person said "I feel they could do more activities" and "There are no activities." Another expressed some regret that there was very little to do and no outings. A relative told us "There used to be outings and activities but these are non-existent now."

In the reception area there was an activity board which indicated a full programme of activities; however, when we asked staff if they followed this they told us that they don't have the time to offer activities on top of the basic care and routine tasks.

We saw that people were encouraged to offer feedback, share their experience or raise concerns. We saw that at the

Requires improvement

Is the service responsive?

beginning of October 2015 surveys had been distributed to the relatives of all the people living in the home in an attempt to gain a better understanding of what they were doing well and where they need to improve. The manager told us six responses had been received and they were hopeful that they would receive more to capture as many people's thoughts as possible.

We saw there were policies and procedures in place to ensure that all complaints were dealt with in a satisfactory manner. People living in the home told us they knew how to make a complaint although they had not seen the complaints procedure. One person told us "I've not seen the complaints procedure and I've never put in a complaint, but I would if I wanted to. If I was concerned about the care I would raise it with the senior." Another said "If I needed to complain I would go and see the head of the service." One person we spoke with told us they had been at the home for a long time and were happy to stay. They said "I have no complaints but would be happy to speak up if needed." We asked who they would speak to if they had an issue and they said "I would speak to the manager." One person told us they had recent experience of complaining, they said "I have complained in the past, but the new manager sorted it out."

We looked at the complaints file and saw that the way in which complaints had been managed was inconsistent. We saw that not all complaints had been addressed promptly and this had allowed issues to escalate.

However, we saw that since the new manager had come in to post any outstanding complaints had been resolved and new complaints had been resolved in a satisfactory manner. We did note that the complaints record paperwork did not include a 'lessons learnt' section. This is a key in helping to ensure that the same issues do not reoccur.

The manager told us they were in the process of setting up a suggestion box and that they were sending letters to all relatives which would include the homes welcome pack which would also outline the complaint procedures. These were also being made available in all bedrooms. This would ensure that people knew how to raise concerns and what they could expect from the home in response.

We recommend the type and availability of activities is reviewed and that all people living in the home are provided with an opportunity to engage in an activity of their choice.

Requires improvement

Is the service well-led?

Our findings

We found that there was a quality assurance system in place but it could be developed further. We found during our inspection that a range of audits were carried out to ensure that the systems at the home were being followed and that people were receiving appropriate care and support. These audits included, for example, the environment, medicine systems, recruitment systems, care plans, maintenance of equipment, health and safety, infection control systems and accidents/incidents. We saw that although the manager was trying to ensure all audits were up to date we found the system had not been completely effective.

Audits of care plans had not identified that the MCA guidelines had not been followed, we noted that staffing levels had not been adjusted to increase the levels of interactions for people in the home and to improve the dining experience for people and we also saw that there were no audits carried out to assess people's views on the activities that had been offered within the home. We also noted that some record keeping was not consistent. Without this information the registered provider may find it difficult to evidence how they are effectively monitoring the quality of the service and staff practices.

This was a breach of Regulation 17. Good Governance, of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found that standard of recording in the home was inconsistent. All of the people living in the home had the amount and type of food and fluid recorded on a daily basis. However we saw that these were not always accurately completed. Fluids were not always tallied and there was also no information or advice included to indicate how much fluid should be consumed during an average day and how staff should respond if a person's fluid intake fell below a certain level. We saw that people who were at risk of developing pressure sores had repositioning charts in place to ensure they were repositioned within a specific timeframe to alleviate pressure on areas of fragile skin. However we saw that these charts were also not accurately completed. For example, we saw one person's chart stated that they had been repositioned on to the same side on four consecutive occasions. We also saw some charts did not include the person's name and dates were sometimes not recorded. We discussed this with the manager and they told us that they would address this with staff through their supervision and in the next staff meeting.

The registered provider is required to have a registered manager in post and on the day of the inspection there was a manager in post who was registered at another location with the Care Quality Commission (CQC). However, they had submitted an application for registration. The new manager had been appointed in September when the previous manager had left the service.

All of the people we spoke with felt that the new manager was approachable and that the home had improved since they had been appointed. One member of staff told us "[Name of manager] is approachable. I can go to them with a problem and they deal with it there and then." Another said "[Name of manager] really cares about the residents; they are approachable and sort things out quickly." Another told us "The new manager listens to what you have to say, they are tougher and more organised."

We spoke to one relative who told us they were reassured from what they had seen of the new manager. They said that the homes staff and especially the new manager were "Receptive to any concerns and acts on them."

Staff told us that they felt that morale was very low amongst the staff team. However, they also told us that they felt it had improved since the new manager arrived and they were confident that with all the changes that had happened this would continue to improve. We spoke to a member staff and they told us that prior to the new manager's appointment they had considered leaving. They told us that since the new manager's appointment morale had improved and as they now knew that the manager would be checking to make sure they had done their job properly, this resulted in them having a sense of pride in their role. They told us that issues that were previously ignored were now being addressed and action was being taken.

Staff told us they attended staff meetings and received regular supervision. We saw that the supervision sessions that had been completed were very thorough and addressed any issues that had been brought to the supervisor's attention. For example, we saw that that the manager had already started to address some of the concerns that had been raised during the inspection prior to our visit. This included staff interaction with people

Requires improvement

Is the service well-led?

living in the home, the need for accurate recording of food and fluid charts and the need for people living in the home to be occupied and not left without anything to do. We saw that supervision had also been used to discuss current legislation in relation to best interest meetings and the Mental Capacity Act (MCA).

We were told staff meetings were carried out on a monthly basis however we found that the last staff meeting had taken place on the 16 June 2015. We discussed this with the manager and they told us that as the home was going through a number of changes they had tried to meet with all the staff individually to provide an opportunity to discuss any issues or concerns in private. They told us that a meeting would take place once they had managed to speak with all staff, although a date had not yet been finalised.

The manager told us they had recognised the need to encourage some staff to take on additional responsibilities if they felt they were ready for this. They told us that they had started the process of identifying 'champions' for different parts of the home and they had recently appointed one member of senior care staff as the 'medication champion'. This role would help ensure that people were receiving medication in a way they were happy with and also help with ensuring that medication was accounted for, delivered on time and was safely and securely stored. The manager hoped to allocate more champions over the coming months.

We observed the handover meeting between the morning and afternoon shift. The staff discussed each person living in the home individually giving an update on any current issues, any change in need, any health concerns, any appointments and how they are in general. This meant that important information was shared and staff were kept up to date on any issues, concerns or changes in need regarding people living in the home.

We saw that the staff were aware of the registered provider's management structure and knew both the regional manager and regional director in person. All but one staff member felt comfortable approaching them and felt they were receptive to their ideas. One person told us "[Name of regional director] asked us what would make the home better and we provided them with a plan of how we could clean all the bedrooms and for the last two weeks it's been working." However, one person felt that they were dismissive and did not listen to their concern. The manager told us they had been well supported since they took the role and that any requests they had made for funding to make the necessary improvements had been granted.

Services such as Red House that provide health and social care to people are required to inform the CQC of important events that happen in the service. The manager of the service had informed the CQC of significant events in a timely way and positive dialogue has continued since the inspection was completed. This meant we could check that appropriate action had been taken.

The manager recognised the need for a cultural change amongst the staff group, but explained the home needed to ensure it was doing the basics right first. They told us that once the current issues were resolved and staff morale improved then a more positive culture would be developed within the home.

We recommend that the home seeks guidance on the accurate completion and auditing of repositioning and food and fluid charts.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing People were not protected from the risks associated with insufficient numbers of staff to meet the needs of the people living in the home. Regulation 18 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent People who used the service were not protected against the risks associated with receiving care and treatment they had consented to or which had not been agreed in a best interest forum. Regulation 11 (1)(2)(3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider did not have in place effective systems to assess, monitor and improve the quality and safety of the services provided in the carrying out of the regulated activity. Regulation 17 (1)(2)(a)(b)