Randale Care Limited

Red House Residential Home

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection took place on 19 June 2018 and unannounced. At the last inspection to this service on 29 March 2017 we found the service was good in three of the key questions we inspect against but we found a breach of regulation in safe. People were not receiving their medicines as intended. We rated the service requires improvement overall. The service immediately took actions to ensure people received their medicines as intended and told us what actions they had taken to demonstrate their compliance. At our inspection on the 19 June the service was compliant throughout and rated as good.

This service is registered to provide both a domiciliary care agency and a residential service. It provides personal care to people living in their own houses and flats in the community. Red House is a care home. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. At the time of our inspection there were 11 people living at Red House. It is registered for 15 people. There was also a person coming in once a week for day care. The domiciliary care service supported 20 people.

Red house had shared communal areas and individual bedrooms on the ground and first floor. There are separate offices at the back of the house from where the domiciliary service is managed from.

The service had a registered manager overseeing two residential services in the local area of Thetford. Both come under separate registrations so require separate inspections. Attached to Red house residential service there is also a domiciliary care service which is registered under the same umbrella as the residential service. The general manager has responsibility and oversight for this service. They have delegated some responsibility to another member of staff who oversaw and managed the staff and coordinated the care.

A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Improvements were noted at this inspection with regards to the safe administration of people's medicines. We identified a few things which could be improved upon and these were actioned straight away by the general manager.

We found on the whole this was a solid good service which was small and personable. It also offered flexibility in as much as it supported people in their own homes as far as possible but also provided residential and some day care. This meant they could support people with a wide range of needs and had enough staff to do so. The service was well planned and well managed so people felt safe with their care delivery and found the service reliable. The only exception to this is some people living in the residential home raised concern about only having one member of night staff on duty. However, there was an on-call

system and we did not find any evidence that people's needs were not met at night.

Risks to people's safety were well managed and the environment had been assessed as safe. Where risks were identified there were sufficient control measures to reduce the level of risk as far as reasonably possible.

Staff were well supported and were only appointed after going through a recruitment process. This could be a bit more robust to help ensure only suitable staff were employed.

The service was hygienically clean but refurbishment of the service meant it was difficult to assess this completely. People living in their own homes received support around their assessed needs which might include support with personal care, taking medicines, managing a home or social support.

The service monitored accidents and incidents and took steps to reduce these whenever possible. They also ensured staff learnt from specific events to help ensure they did not happen again.

Staff received training, induction and support around their specific job role. This could be explored further to ensure staff support was adequately recorded and staff were supported in accordance with the regulated activity they were carrying out.

Where needed, people were supported to eat and drink in sufficient quantities. People's weights were monitored to help ensure a healthy weight was promoted and people stayed sufficiently hydrated.

People or, where appropriate, their relatives, consented to their care and their choices were respected. Staff had received training in the Mental Capacity Act 2005 (MCA). The MCA ensures that people's capacity to consent to their care and treatment is assessed. If people do not have the capacity to consent for themselves the appropriate professionals, relatives or legal representatives should be involved to ensure that decisions are taken in people's best interests according to a structured process. There remained some confusion in records with regards to consent to care and treatment but it was clear that people, or their relatives if appropriate, were being asked.

People had their health care needs met and there was enough information for staff about how to meet people's needs. Some additional training around people's specific needs might be helpful.

People had their needs assessed, planned for and reviewed and received effective care.

Care was provided around people's preferred routines and preferences and care staff were respectful of people's cultural needs and need for privacy.

People felt consulted about their care needs and the service considered feedback from people whether it was positive or less so. There was an established complaints procedure and a quality assurance system.

Some activities were provided in the residential service and people were supported to stay active and engaged. This varied from person to person and some felt there were not enough activities.

The service was well managed and transparent. All the staff from the general manager to the care staff contributed to the smooth running of both services.

Staff and people using the service had confidence in it and felt it to be well managed and well organised.

This reduced risks and enhanced people's wellbeing.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Minor issues were identified with the safe administration of medicines but these were rectified immediately and did not have a significant impact on people using the services. Systems and processes had improved since the last inspection.

Staff recruitment was sufficiently robust to help ensure only suitable staff were employed.

Risks to people's safety associated with their care and, or the environment in which care took place were effectively managed.

Lessons were learnt when things went wrong and the service had adequate systems in place to record and monitor events which affected the safety of people using the service.

Staff received training to help them recognise safeguarding concerns and they knew what actions to take to report concerns.

There were enough staff to meet people's assessed needs although some people were not so confident this was always the case at night within the residential service.

Is the service effective?

Good

The service was effective

Some improvement was required with regards to records documenting decisions about people's mental capacity but we found in practice staff did support people appropriately.

Staff were sufficiently trained and supported through induction and in the work place.

People were supported to eat and drink sufficient to their needs and their health monitored.

The induction for new staff was adequate but was being reviewed to ensure it was more robust.

Staffs' knowledge and practice was up to date.

Is the service caring?

Good

The service was caring.

Staff knew people well and responded to their individual needs.

Staff promoted people's independence and promoted their dignity.

Staff consulted with people about their routines and preferences and the wider service.

Is the service responsive?

Good

The service was responsive.

People had their needs assessed and their care plans showed how their needs were going to be met. This was kept under review to ensure the support was still appropriate.

Activities were planned around people's individual needs but there were days when there were no planned activities.

The service asked and responded to feedback from people and others and this helped the service improve where necessary.

Is the service well-led?

Good

The service was well led.

Each part of the service provided good outcomes for people using the service.

There were several things that could be improved upon but most felt the service was open, responsive and communicative. The director responded immediately to our feedback.

The service was well planned and well delivered.

Improvements were ongoing and considered feedback for people.

Red House Residential 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.

The inspection took place on 19 June 2018 and was unannounced. The inspection was planned in line with our methodology and within the specified return date to check improvements made since the last inspection.

The inspection took place over one day but additional information was requested following the inspection. We also spoke with several people and a staff member following the inspection.

The inspection was undertaken by two inspectors and one 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. We received a provider information return before our inspection which gives us information about the service and what is in place to meet the required key lines of enquiry we inspect against. We reviewed information already known about the service such as previous inspection reports and notifications which are specific events the service is required to notify us of.

The service provides two regulated activities but only has one registered location. We inspect against the location so looked at both elements of this service but are only required to complete one inspection report. For the domiciliary care service which currently supports 20 people we spoke with two staff and met a further three staff. We carried out visits to three people and spoke to a further two over the telephone. We met one relative. We reviewed care plans and risk assessment in each person's house.

For the residential service we spoke with two visiting professionals, one relative, two activity staff and four

people using the service. We spoke with the general manager, the deputy manager, two care staff and the staff member cooking people's meals.

We reviewed care plans and risk assessments for three people and a sample of people's medicines records. We also checked a selection of records associated with the quality and safety of the service.

Good

Is the service safe?

Our findings

At our last inspection to this service on 29 March 2017, we found systems for managing medicines were not as safe as they should be. There was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014. Following the inspection, the general manager told us how they would improve medicines management and at our inspection on 19 June 2018, we were able to see the improvements that had been made and sustained. However, we identified further improvements necessary which were made straight away and confirmed by the general manager.

We checked the balances recorded as received or in stock with the numbers of tablets staff had given and found these tallied, representing improvement. Medicines administration record (MAR) charts in use from 4 June 2018 were complete, with no missing signatures. There was clear guidance for administering medicines and staff's obligations to report any concerns or missing signatures at each medicine round. The management team were completing more regular and robust checks on medicines so they could identify or address any concerns promptly.

Medicines such as eye drops and inhalers when opened were not always dated. This meant we could not be assured they were still in date and remained effective. The general manager confirmed that all medicines were returned at the end of each month when the new supply arrived, including any unused eye drops and inhalers. However, they did also take action to date the packets to help avoid the risk.

Staff were aware of time critical medicines and specific instructions such as medicines which should be administered before food. Some people had prescribed medicines to reduce digestive problems. These were to be administered half to one hour before meals. However, they were included in the 9.00 am bio dose system and some of these medicines were still being administered by 10.00 am. This meant the medicines might not be effective in managing/controlling people's symptoms. This was acted upon immediately to ensure people received their medicines at a suitable interval before their breakfast.

Some medicines were prescribed for occasional use when people needed them (PRN). Although staff were clear about their use there was not always clear guidance in place. The general managers confirmed following the inspection these were now in place.

One person received one of their medicines covertly, but took the others without them being hidden in food or drink. The MAR folder indicated that this was agreed with the GP as needed for their wellbeing. However, their care records lacked an assessment of their capacity to understand and make informed decisions about their medicines. The process for verifying they did not understand the implications for their wellbeing, and that covert administration was essential in their best interests, therefore needed to improve.

Staff confirmed that they had training in medicines management and that a member of the management team observed them giving medicines until they were competent and confident.

Medicines were stored securely, with keys locked away in a key cabinet when staff trained in medicines

management were not using them. The management team had recognised the risks associated with limited storage facilities for medicines. They had implemented regular checks of the temperature in the storage area. They had assessed risk and developed guidance about what staff needed to do if this rose about acceptable levels.

We visited three people being supported in their own homes and spoke with a further two people on the telephone. None had support with taking their medicines. The general manager told us they currently only supported one person with medicines and this was from a dossett box. They confirmed the trainer employed by the service had an advanced medication qualification and training was provided in house and included both practical training and through DVDs. Staffs competence was assessed during their probationary period. There was some evidence to support this but some staff were not assisting with medication administration so had not had competency assessments.

The service provided to people was as safe as it could be with risks assessed, documented and mitigated as far as reasonably practical to do so. People told us they felt safe. One person in their own home said, "I can be very anxious, but I trust the staff, they work flexibly around my needs." A relative told us about their family member in the care home, "This is the right place for her, she's in good hands here, they look after her really well." A person using the service said, "I can press the bell if I need anything, they come straight away."

Staff understood the importance of reporting concerns and suspicions about abuse, which helped keep people safe. Staff were clear about what would lead them to be concerned and confident that the management team or general managers would address concerns appropriately. One commented that, if they felt their suspicions were not being acted upon and referred, they would contact the Care Quality Commission. There was information about how staff could contact the local authority directly to raise safeguarding concerns in the staff office. Within people's homes there was guidance available which told them who they could report their concerns to and gave details of out of hours support and external agencies.

People being supported in their homes had an initial assessment of their needs and any risks associated either with their care or the environment in which the care was to take place. People were confident that they were safe and there were suitable arrangements in place regarding access to the property using a key safe or another agreed way to access the property. Confidential information was kept safe. Domiciliary care staff completed monthly checks of smoke detectors, pendent alarms, and any specific equipment used. For example, one person had risk assessments and visual checks on their hoist, manual handling slings and commode.

One person we visited had multiple visits and complex health needs due to a physical condition. They had all the right equipment in place and a very detailed manual handling plan. The plan clearly highlighted the risks and how the person should be moved safely. During our visit the person was initially being supported by two staff with their personal care. The person told us they trusted the staff and clearly got on well with staff given the laughter and banter between the person and staff supporting them.

Comments in people's surveys, analysed in January 2018, showed that they felt safe when staff assisted them with their mobility. One person felt this was "usually" the case. The analysis showed how the management team addressed this with the person, reviewing their needs to ensure the person was supported safely.

There were no assessments of risk to people's skin integrity within the care plans reviewed. However, visiting health professionals confirmed they felt this was well managed. They described staff as knowing what to

look for that might indicate concern and increasing risk. They also confirmed that staff acted to make prompt referrals to their team and to ensure the right equipment was in place. One professional confirmed to us that they had visited and seen the equipment they supplied, such as pressure relieving cushions, in place for the right people.

We saw assessments of risk for people who may not eat and drink enough. Staff reviewed these regularly and monitored people's weights. The records also showed that the registered manager reviewed them at intervals to see whether any additional action was necessary. The visiting health professionals were satisfied that staff managed this aspect of people's care and safety appropriately.

One incident within the home led to a specific assessment of risk and recognised triggers that could present problems for a person. The general manager gave a clear explanation of the circumstances and the actions taken to promote safety and wellbeing.

The management team assessed risks associated with the home and to individuals in the event of an emergency such as a fire. In one of the three care plans we reviewed, there was no personal emergency evacuation assessment guiding staff about supporting them to leave if there was a fire. However, there was an overall assessment of level of risk for them within the file used by staff in emergencies. This was appropriately located in the hall near the fire panel so staff could access it quickly in an emergency.

Records showed that systems for detecting and extinguishing fires were tested. Two emergency lights had failed when tested the day before our inspection visit. The general manager stated that repairs were in hand.

Window restrictors were not in place for upstairs windows but the general manager said this was assessed on an individual basis. We said the assessment needed to consider not just the individual but anyone else who might enter the room with unrestricted windows. The general managers said the unrestricted windows use to have chains on them but had been removed since the refurbishment. There were risk assessments in place to consider any potential risk created by the refurbishment. They reassured us the unrestricted windows would be addressed immediately.

Staff told us that they had training in fire safety and records confirmed this. However, one member of staff was not clear about at what point they should call the fire brigade suggesting that they would telephone the manager and check whether and where the fire was. They did confirm that night staff would always call the fire service straight away.

Staffing was appropriate to people's needs. In the residential service there were two care staff on shift with additional support from a staff member preparing the lunchtime meal and drinks. On the day of our visit, there were separate staff assisting people with activities, although this did not happen every day. There was one waking night staff member with another member of staff sleeping on the premises. They told us that nights were not usually disturbed. During our inspection visit, staff responded to people's requests for help promptly.

Staff and the management team present during our visit, confirmed that they felt staffing levels were sufficient to safely support the 11 people living in the care home. In addition to the two staff on duty, they said there was a member of the management team present during the week. However, this was not the case at weekends. Staff explained that there were "on call" arrangements in place when a member of the management team was not present. The deputy manager told us how the "on call" system worked and that the "on call" person had to be available to attend the care home for support in no more than half an hour.

We noted that the analysis of people's surveys showed that no one felt care staff did not spend enough time with them. Four out of six people responding said that staff fulfilled the tasks they needed to do. Two said this was usually the case and the report showed the management team would look at this again at the next review. The service did not have a staff dependency tool in place which considered people's assessed needs and levels of required support and how many staffing hours they needed. This might provide a clearer rationale of numbers of staffing hours deployed.

People being supported in their own homes were happy with the staffing levels and told us they had not had missed calls and calls were largely delivered on time. The service worked at a team to ensure peoples hours were covered. There was some overlap with some staff working in both the domiciliary care service and residential service. Staff were subject to the same mandatory training but had service specific guidance. People were given rotas in advance so they knew who was coming and staff had their allocation of calls in good time.

There were measures in place to control the spread of infection. However, it was difficult to assess overall cleanliness in parts of the home, specifically communal areas, because of refurbishment work taking place throughout the home. Also on the day of our inspection the domestic staff were on leave. The general manager has since told us that they are recruiting for a relief domestic to ensure there is always adequate cover. The service did complete regular cleaning schedule audits and had identified for themselves any issues that needed addressing within agreed timescales for completion. Much of the home, including toilet and bathroom areas, was clean. We saw there were pedal operated bins for disposing of protective gloves/aprons and pads, so staff did not need to touch the lids and risk contaminating their hands. There was guidance for staff about colour coding of equipment to avoid spreading infection from one area to another, such as from toilets to kitchen. We noted that there was an accumulation of dust and dirt on the skirting boards within the staff office.

Care staff were expected to fulfil cleaning tasks including laundry. We noted that there was a schedule for cleaning communal areas that the waking night staff member was expected to follow and they signed to show the tasks they had completed. Staff had access to, and used, personal protective equipment such as disposable gloves and aprons.

The management team reviewed accidents and incidents taking place within the home, to see if additional action was needed to address concerns or developing patterns. We could see from accident records whether they had taken action in response to individual incidents. The registered manager had also completed a record reviewing such incidents as falls, to see if there were patterns developing that needed addressing.

We noted there had been one missed visit to a person in their own home with no ill effect. This had been dealt with appropriately and adequately responded to with the service taking responsibility and putting in steps to ensure lessons were learnt. We were confident that the service was open, transparent and learnt from mistakes. It had embedded a culture in which staff were supported and people knew the service were accountable for the service they provided.

Staff told us they were notified or any concerns or incidents within the service and the service kept them up to date with any changes or policy updates.

There was safe recruitment of new staff. We reviewed several staff files. These had the necessary paperwork to check staff had the right skills and attributes. There was a record of their previous employment history, job references and proof of identification. A disclosure and barring check was in place which checks to see if

staff have a criminal record or have committed offences which might make them unsuitable or barred for working in care.

Job descriptions and job contracts were in place but these were generic and not service specific which they should be to consider the differences between the two different regulated activities. Staff interviews notes were seen and showed the process for staff selection. However, these were not sufficiently thorough. For example we saw for existing staff previous convictions had been declared and discussed as part of the interview process. The provider told us this but confirmed this was not recorded to show that they had considered if there was any risks associated with their employment The general manager said if a person failed to declare any convictions on their application form or at interview their employment would be terminated. The interview questions were non-specific and generic and could focus more on expectations of the job role and the people they were likely to support.

Good

Is the service effective?

Our findings

The last inspection to this service was 29 March 2017. The service was compliant with this key question and continues to be so. However, we identified several issues which the general manager should address but have confidence that they will do so.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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 decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes 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.

People's capacity to make specific and individual decisions, were not always clearly documented. Care records did not clearly demonstrate processes consistent with the MCA and associated code of practice. We found one person's capacity to understand and make an informed choice about taking a medicine, had not been assessed and recorded. Their GP was consulted about the medicines and their care notes showed this. However, there was a lack of clarity that proper processes had been followed and who else was involved in determining their best interests. This was raised at the time of our inspection and the general manager agreed to review this as a matter of urgency.

The same person's care records showed that they agreed to their care plan but also that they had "no capacity" to understand it. For a second person, their information was clearer, that they could understand information but were unable to retain and evaluate it to make a decision. There was a conclusion that they had no capacity to decide about their personal care, medicines, and sharing personal information with others. However, the next section showed that they had been asked to sign, and had done so, to give their consent for "… the proposed examination, care, treatment or support stated on page one." This was despite the initial assessment suggesting they could not make an informed decision about whether or not to do so.

Their record also showed that a named representative had lasting power of attorney (LPA) to make decisions on their behalf about care and welfare, where the person themselves was not able to do so. A copy of the authorised LPA was not on file to confirm they had legal powers to make such decisions.

The general manager explained that they were in the process of chasing those representatives who claimed authority, for the information to support this. Pending the information, there was a risk, given the lack of clarity in records, that decisions may not be in accordance with the MCA.

Staff understood the importance of seeking people's permission to deliver care and we saw people's signed consent for their care and support. They told us how they would offer choices, and respect people's views. Where people needed assistance that was essential for their wellbeing, they said they would return at another point or ask another member of staff to do so, to see if they could get the person's cooperation and agreement. Staff also described to us how their recent training in dementia care, had improved their awareness of how to communicate with people. They said that this had influenced how they asked questions in a way that enabled people to process the information and make choices. A staff member spoken with also reflected to us how any developing infection affected people. They were aware that infection could make people confused and less able to make choices.

The general manager had a clear understanding of when an application under DoLS was required. During our inspection visit, they explained the processes they were following for one person with other professionals involved in their care and an advocate. The application considered necessary was in progress.

Within the care home, there was a core of consistent staff, together with stable management, who understood people's needs, likes, dislikes, and preferences. Staff told us that they felt there was sufficient guidance in people's plans of care to ensure they knew what support each person required to meet their needs properly. There was limited use of assistive technology to promote independence, although the care home was not a specialist dementia service.

People's responses to the provider's survey, analysed in January 2018, showed that they felt staff were well trained to support them. Staff told us that they were informed when updates to their mandatory training, such as moving and handling or first aid, were due, so that they could renew this promptly.

Staff in the care home told us how much they had enjoyed and valued recent training in dementia awareness. The use of training aids and technology had enabled them to experience how living with dementia could affect people and their perceptions. Two staff told us how they felt this had changed the way they communicated with people and helped them understand why people may react in a way.

Several people being supported in their own homes were younger adults who needed support due to their mental health needs. We noted staff had not had training in this area of mental health and staff said it could be difficult at times to support people who might be in acute mental distress. The general manager told us although they did not have specific training they did complete in-depth assessments and would ensure staff had the skills to meet people's assessed needs. They said they supported care staff by gathering as much information as possible and working closely with the mental health team and social workers. They have agreed to source training going forward.

The general manager told us how they were improving induction training for new staff. They explained that there was an assessor for the Care Certificate at their other service. The Care Certificate represents best practice in induction training for staff who are new to care. They were intending using the assessor to support new staff so that everyone who did not already have a qualification in care, would complete the Care Certificate. Experienced staff confirmed to us that staff new to Red House completed shadowing shifts with them to support them understanding their roles. There was a twelve -week induction programme with evidence of initial training completed, shadow shift dates and any observation as well as a probationary review. This helped ensure new staff were adequately supported and were confident in their role.

Staff told us they felt well supported by the management team. They said that both the registered manager and general manager were approachable if they needed advice or support, both formally and informally. However, they were inconsistent about how often they received one to one supervision to discuss their

performance and development needs. For example, one staff member told us they thought this happened about once every three months, and another said the frequency was six monthly. Records did not help us clarify the frequency of supervision. The general manager said they were addressing this and redeveloping the staff appraisal form to include outcomes and goals. Supervision took different forms including observation of practice, staff meetings and one to one support, so did occur regularly.

Spot checks were carried out in the domiciliary care service to check staff were where they should be and adhering to the persons care plan. They would also check that staff had the correct uniform, identification and were delivering care and support effectively. We saw some records of spot checks but were unable to establish how often these were undertaken as responsibility for who undertook these had changed recently. Staff and people, we spoke with confirmed these spot checks went ahead. One person told us staff were observed when delivering the care and support and the reasons why this was necessary had been explained to them. They told us they had given consent for these observations to take place. They also explained that new staff came with a more experienced carer to be shown what to do. Everyone spoken with were confident in the abilities of the care staff to deliver effective care.

People were supported with their nutritional needs and were offered a variety and wholesome diet. One person told us, "The food is absolutely out of this world." We wanted to check, so asked if they meant in a good way. They smiled and nodded. Other people were not quite so enthusiastic, for example one person said, "It's ok, sometimes it's alright, other times I'm less bothered about it." We noted one person who was vegetarian had their needs accommodated. Another ate very little and told us they had not liked it, staff did not ask them about the food or if they would like to try something else.

Within the care home, staff monitored people's food intake to ensure that they had a variety of food and had eaten or drunk enough. We observed staff encouraging one person who said that they did not have a good appetite. This included encouraging them to sit with a staff member who was eating their own lunch at the table with people.

We heard staff offering people choices about what they wanted to eat. Options on the day of our inspection visit were an "All Day Breakfast" or salad. One person opted for the salad. A relative commented in the provider's survey, analysed in January 2018, that, "My [family member] regularly comments on the high quality of food." Another stated that their family member had a much better diet in the care home than they had previously.

Staff told us that people could eat where they wanted and that some people would choose to take some of their meals in their own rooms. Some people were still eating their breakfast when we arrived for our inspection visit and were not rushed to complete it. One person had declined their toast because they had eaten cereals and said they really did not want any more.

Staff offered people a choice of drinks very regularly throughout the day. We observed one staff member encouraging people to accept another drink because the weather was warm. We also saw that another staff member taking drinks round, clearly knew people's preferences and what they usually had. However, they showed that they did not take this for granted. We heard that they asked people if they would like "… your usual or something else?" They offered other options in each case, of both hot and cold drinks.

People being supported in their own homes had a detailed assessment and plan of care which agreed the tasks identified for care staff to assist with. In some instances, this was around food preparation and monitoring of food/fluid intake where a risk of unintentional weight loss or dehydration through a lack of fluids had been identified. The care plans and daily notes gave us a good indication of how care staff were

fulfilling people identified needs.

Two visiting health professionals told us they had no concerns about how people were supported with their drinking. They confirmed staff always offered people plenty of opportunity to drink and responded to people's requests if they asked for something to drink at other times. They also confirmed staff turnover was low which meant people's needs were known well and provided for consistently. They said staff were quick to identify and refer any changing or unmet need.

The last survey response conducted by the service was analysed in January 2018, showed people felt their dietary requirements were met.

The dining room had recently been redecorated to provide a pleasant and homely environment for people. However, the adjacent lounge was being refurbished at the time of our inspection visit. This meant that the dining room was very full of a lot of furniture that could otherwise have been more spread out and easier for people to move around.

People's care records contained a form for staff to use if they transferred to hospital, so that hospital staff would have essential information about their needs. However, we found that none of those we reviewed were completed for use in an emergency where they might be needed at short notice.

One person had transitioned from the provider's own domiciliary care service to the care home. A relative had commented that this was handled patiently and properly so they could make the change from care in their own home, to residential care.

People being supported in their own homes told us staff were responsive to their changing needs and told us about things staff had identified and had ensured this was followed up with the correct health care professional. One person told us about a recent hospital stay and said the whole time they were there staff stayed in touch so were aware of how they were feeling and progressing. One relative said, "If she needs to be seen, it's not a problem at all, the carers will arrange for the doctor to see her." A person using the residential service told us "There's a chiropodist comes in, once a month I think, so I get my feet done." We asked them whether this was arranged by the care home or a member of their family and they said, "Oh the carers, they organise anything like that."

People in the care home were supported to gain advice about their health and wellbeing and to access health and social care professionals. Two visiting health professionals told us that they felt staff sought advice from them appropriately and acted upon it, to promote people's welfare. One described it as rare for any advice or action they suggested to be missed. They told us they had no concerns about the standards of care and support the staff team offered.

One health professional went on to explain that they felt they had developed good relationships with the staff and management team. They said that this made it easier to raise issues of concern if there were any, and to resolve them professionally.

The environment was mostly suited to purpose and there was an extensive programme of refurbishment taking place in the care home. Information we saw suggested that this would consider the creation of an environment that was both homely and aided people who lived with dementia. We were not able to fully assess how this was progressing because work to communal areas was still in progress.

People made positive comments about their environment. One person said, "My relative had got one of the

best rooms, it's a good size and looks out over the front garden. There are bird feeders which I keep topped up and she can watch the wildlife which she likes to do." We saw that the room was a good size, well decorated and personalised with photographs. It appeared clean and tidy and had places for visitors to sit.

There was a paved, level patio area outside the sun lounge. Handrails protected this so that people could use it safely. Access outside and around the home was variable, with a gravel driveway. However, with staff assistance, two people walked around outside during our inspection visit and enjoyed the fresh air.

There was some bedroom accommodation on the first floor of the home. This was accessed by a stair lift and so consideration had to be given to individual risks and understanding of safety for people using that area.

Good

Is the service caring?

Our findings

At the last inspection on 29 March 2018 this key question was rated as good and remain good at our latest inspection on the 19 June 2018.

We found people received support that was delivered in a caring manner. We asked people in the residential home if staff were kind to them and if they could give us any examples of this. One person told us, "They know I love all animals and one of the lady's is going to bring her kitten in for me to see, I'm looking forward to that." This was confirmed when we spoke with the member of staff. They went on to say that at the home they got squirrels and muntjac deer visiting. When we observed staff taking round the drinks, one person commented, "She's lovely she is, they're all kind to me but some are really nice." Another person told us, "The staff are wonderful, I cannot fault them, they are very kind and that does make a difference to me."

People's survey responses, analysed in January 2018, showed that everyone who responded felt staff were polite. A relative had commented in their survey that, "All the staff are welcoming and kind to clients and their family and friends who visit." Another wrote, "The carers are pleasant to [family member]. They attend to [person's] needs and they are kind."

People told us they were supported by staff familiar with their needs. People being supported in their own homes commented on the regularity of the support they received which was dependable and something they looked forward to. Although people told us they had different carers, sometimes as many as eight, they were happy that they got to know all the staff and felt they all worked to a high standard and were very personable. The trainer for the company who also managed staff told us they got to know people well and could meet their requests. They said, for example some people did not want to have a male carer and some preferred not to have the younger carers. They matched staff to clients based on their specific needs and considered staffs experiences.

Whilst visiting people who received support in their own homes we found staff had developed good relationships with people and they were clearly comfortable in staff's company. Staff chatted, laughed and joked with people and this was lovely to see. One person told us how their physical illness could drag them down but said staff were sensitive and were always cheerful which helped them through their day. They said, "As my disability progresses I find this mentally challenging. Staff cheer me up they are reliable, and never miss a visit. They are my second skin."

We observed that staff responded to people promptly, engaged them in conversation, and always addressed them by name. We saw that they made eye contact with people and gave them time to respond. They offered reassurance to people when this was needed.

Staff spoken with could explain people's backgrounds, so that they could engage with them in a meaningful way about things that were important to them. They spoke passionately about their work and respectfully about people when they were talking to us. Within the residential service, staff often recorded people's life stories and significant events. However, this was not the case in the domiciliary care service where staff said

they did not record this. They said they would record any family involvement. It would be helpful to have a bit more detail particularly where people have a cognitive impairment and might not be able to tell staff about their history or important things about themselves which might influence their personality and behaviour.

Two visiting health professionals told us that they had never had any concerns about the way they had seen or heard staff interacting with people. One told us that they had never seen anyone living in the care home responding unhappily to staff.

Four people responding to the provider's survey felt staff always respected their privacy. Two said this was usually the case and the provider's analysis showed that they had followed this up with the people concerned to see how their experiences could be improved.

We observed that staff offered assistance to people with their personal care in a discreet manner, for example when they asked people if they needed help to use the toilet.

People told us they could make choices about their daily routines. For example, one person told us, "I decide when I go to bed, it's up to me. Also, there's quite a few things I choose to do such as whether I eat in the dining room or somewhere else. It's only small things really but I am able to decide for myself." Most people were happy with their care but some felt care could be compromised a bit at night when there was only one waking night staff. One person said they were worried people might not get the care they needed, another felt they could not go to the toilet when they wanted because they needed assistance. We discussed this with the director who said people's needs were assessed and any change in need would result in a review of staffing.

There was evidence within care plans, that people had been involved in compiling them. This included describing what made a "good day" or "bad day" for each person so staff knew what was important to them. Where one person had not wished to engage in discussion about significant events in their history and background, their refusal to participate was recorded.

We noted that one person's advocate, assisting them to complete the provider's survey, had said that they did not feel the person was offered choices within their care plan. The director's analysis of this showed that it was followed up. None of the people responding to the director's questionnaire felt that they were not involved with decisions about their care or that staff did not listen to their thoughts and decisions.

People's daily notes, compiled by staff, showed that some people were able to be independent in aspects of their care and were encouraged with this.

Good

Is the service responsive?

Our findings

At the last inspection on 29 March 2017 we rated this key question as good and have not changed the rating following our recent inspection on the 19 June 2018.

We found people received care and support in a way that considered their individual needs and preferences. Within the residential service we saw for example, one person's records showed that they had not wished to get up when staff offered support. Staff had respected their choice and returned to aid later.

Staff told us about another person who had been unwell and so had wanted to spend the day in bed. They had offered support for the person to wash and change their nightwear and then to remain in bed as they wished. The person's records confirmed this.

Staff supported some people within their own homes at the time of a person's choosing whenever possible. Timings were agreed with the person and there were parameters either side of the agreed time to build in some flexibility to account for emergencies, traffic or other unforeseen circumstances. People spoken with were happy with the timings and reported care staff hardly ever ran late or not without good reason. They said staff stayed the right time and could deliver the care and support within the allocated time. They also stated staff were flexible in their approach and spent time chatting to them.

Daily notes seen in people's homes were in sufficient detail and let us see how staff were responding to people's individual needs.

Within the residential service there were two staff who were designated to support people with activities of interest to them. These staff worked across both general manager's homes and so were not always present at Red House. We noted that both engaged with people in activities and discussing what they would like to do, although much of the focus in both the morning and afternoon of our inspection visit, had been on the same two people.

We asked people in the residential home if they were enough activities to keep them occupied. We observed three people doing some craft work and others being encouraged. One of the activity staff showed us some of the things they had been making to sell at the home's up and coming summer fair which was mostly as a fun activity but also to raise some funds. Staff spent time talking to people about their past but there were things they were unaware of until they overheard the expert by experience talking to people about what they did previously.

Staff described how they did try to encourage people to engage with others. We saw that there was a "petting zoo" soon to visit. The deputy manager explained to a person who was interested, what this would involve. There was also a planned visit from an organisation with "mini donkeys" for people to pet if they wished.

We also saw that there was information displayed about "dementia friendly" film screenings that staff could

support people to attend if they wished to. The next proposed film was Breakfast at Tiffany's. We saw staff discussed this with one person to see if they wanted to go.

Within people's own homes staff supported people according to their needs, some which might be physical, or around their emotional and social needs including support to access the community.

There was an accessible complaints procedure and people were aware of it. One person told us, "They're all nice here, I can talk to any of them." The provider's processes for making a complaint were displayed on a noticeboard in the hallway. These showed what people or their visitors could expect if they raised a concern. The information did not clearly explain how to contact the ombudsman if anyone was not happy with the provider's response to their complaint. However, people who completed the provider's survey expressed confidence their concerns were well addressed by the management team.

We noted that one person's advocate, responding to the general manager's survey, had said that they did not know how to complain. The general managers report following the analysis of responses in January 2018, confirmed that they had addressed this. They had taken action to re-issue the guide for people using the service, and the statement of purpose for the home. We reviewed both documents and saw that they contained copies of information about how to complain.

People in their own homes had access to the complaints procedure and were confident with the service and knew who they could approach if they had concerns. People told us they saw both the general manager, the registered manager and other key staff who would sometimes deliver the care.

There had been no formal complaints about either of the regulated activities. Everyone we spoke with knew how and who to raise concerns to. One person was very unhappy about their circumstances, this was known and the person was being supported with their concerns. This was documented in their record. A family member had raised a specific concern and was immediately given the opportunity to discuss this so their concerns could be explored with individual staff and a plan put in place for moving forward. This demonstrated the responsiveness of the service.

At the time of our inspection visit, no one within the care home was receiving palliative care at the end of their lives. However, our discussions with both staff and visiting professionals showed that this had happened some weeks before our visit. The health professionals said that they felt staff attended to this well, showed compassion, and were caring towards the person concerned. One expressed the view that the standard of care offered had resulted in the person living longer and more comfortably than they had expected. People living in their own homes were supported for as long as the service remained appropriate. Staff said where people were approaching the end of their lives they would continue to support them if their wish was to die at home. They would support a person with the assistance of services specialising in end of life care. Some staff had previous experience and, or training within palliative care. Staff had completed training around funeral care and dispelling the myth. This helped staff understand the process after death and gave staff the confidence to talk about death. Peoples last wishes had been discussed and recorded on some records we looked at.

Good

Is the service well-led?

Our findings

At the last inspection on 29 March 2017 we rated this key question as good and have not changed the rating following our latest inspection.

We asked people using the residential service if they though the service was well led. One person told us, "The manager is friendly and helpful, she's not here today but the lady who is here is one of the bosses, she's good too."

Most people told us they were asked their opinion about the way the home was run. One person said, "They tell me what's happening and they'll put a notice on the board too. They've told us about the redecoration plans and (name of wife) is going to have her room redecorated soon." We commented on the décor to which one person replied, "Well they're going to do it anyway, I know it looks nice now but they've told me they want to improve it."

People when asked said they would recommend the home to others. When asked what they liked about the home one person said, "It's the girls, they make this place." Another person said, "I don't want to be here but I cannot fault the care we get."

The general manager had produced a development plan for the service and ensured resources were available to secure the improvements they wanted to make. This included both of their care homes and the domiciliary care agency. It showed what they were intending to progress and address and how they would go about this. The areas of development identified included improvements to the premises and arrangements for catering supplies for Red House. It also covered the identified need to improve staff induction and the use of supervision during the probation period for new staff.

In Red House, the need to improve the environment was identified and nine of the 12 bedrooms had been refurbished. Further work was in progress to improve communal areas and resources had been devoted not just to décor but also to furnishings and floor coverings.

The general manager was aware of new obligations in relation to data management. This was included in the development plan for the service. They had produced statements covering the principles, explaining the information gathered and the purposes for which it was needed, and how it would be protected.

We spoke with people who were being supported in their own homes about the quality of care they were provided. All without exception said this was a well-run service with clear lines of accountability and communication. All knew about their care plans and said they were reviewed. They told us they were consulted about their care and asked to give feedback about the service they received and said anything raised would be acted upon. For example, one person asked not to have a specific carer and this was acted upon. They told us staff were well supported and delivered reliable, safe care. Everyone knew the registered manager and the general manager and spoke of good team work. Meetings with relatives and people using the service had been held and changes in the service effectively communicated.

Care home staff described morale and teamwork as good. They spoke to us enthusiastically about their roles. They felt that the management team was 'supportive and visible in the home, and their presence was not just because the inspectors were visiting. Staff supervision was in place but could be improved upon in terms of its frequency. Roles and responsibilities were covered through staff's job description but there were no champions within the service. Champions are staff with oversight of specific areas of practice either because they had an interest or a more in-depth knowledge of this area of health care. Their role would be to support other staff and have more oversight. Example being a medication champion. Staff roles were going to be developed, including a dementia champion.

Visiting health professionals expressed their confidence in the leadership of the service, particularly in the long-standing registered manager. They considered this person to be a strong advocate in speaking up for people and securing what they needed to enhance their wellbeing.

There was a registered manager in post, who had responsibility for the domiciliary care agency, the care home at Red House, and the general managers nearby larger care home. One of the general managers and the general manager told us how they were taking steps to recruit a separate registered manager for their other care home. This would enable the registered manager for Red House to devote more time to both the domiciliary care agency and the care home.

People using the service were encouraged to express their views with annual surveys and less formally. In response to the general manager's surveys, their analysis showed whether they considered any further action or discussion was needed to explore people's views and act to improve.

The survey results were good showing high levels of satisfaction across all the questions apart from one which was a known concern and had been addressed.

There were good quality assurance processes in place to measure the effectiveness of the service, identify any gaps and ensure records were of a high standard and demonstrated actions taken. We reviewed audits around health and safety, refurbishment and replacement, staffing, and care plans. We checked fire reports, checks on water temperatures, moving and handling processes and equipment. Other professional reports were available for us to inspect from the environment health department and fire services and these did not raise any concerns.

There were good links with the community which helped to enhance people's experiences. For example, the home was situated on the edge of town and there was good liaison with the local supermarkets and a community volunteer. They had links with the Thetford and District Dementia Support (TADS.) They could put staff in touch with volunteers and befrienders who might be able to support the residents. They also facilitated dementia friends which is an initiative from the Alzheimer's Association who provided some basic training about dementia and the effects this had for the individual and the community. In return for the free training staff would be able to access resources and pass on the training to other groups to increase community awareness. Through this they could also link in to resources and services which might be helpful for people living with dementia. For example, the service has identified a shop selling dementia friendly furniture.