Mr T & Mrs S Kandiah

Remyck House

Inspection report

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Tel: 01252310411

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This was an unannounced inspection which took place on 19 October 2016.

Remyck House is registered to provide care (without nursing) for up to 29 older people. There were 26 people resident on the day of the visit. The building offers accommodation over two floors in 23 single and three double rooms. The double rooms were used for single occupancy, therefore the service had no vacancies on the day of the inspection. The second floor was accessed via a staircase or lift. The shared areas within the service were adequate to meet the needs and wishes of people who live in the home.

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

People, staff and visitors to the service were generally kept safe. However, we have made a recommendation about areas of safety that required review to ensure people were as safe as possible. Most risks were identified and managed to make sure that people and others were kept safe. Staff were provided with training in the safeguarding of vulnerable adults and health and safety. They were able to describe how they kept people safe from all forms of abuse and harm.

There were enough staff to safely support people. The service's recruitment procedure ensured that as far as possible, all staff employed were suitable and safe to work with vulnerable people. People were given their medicines in the right amounts at the right times by staff who had been trained to carry out this task.

The management team and staff protected people's rights to make their own decisions and consent to their care. The staff team understood the relevance of the Mental Capacity Act 2005, Deprivation of Liberty Safeguards (DoLS) and consent issues which related to the people in their care. The Mental Capacity Act 2005 legislation provides a legal framework that sets out how to act to support people who do not have capacity to make a specific decision. People in the home had the capacity to make their own decisions and choices and deprivation of liberties applications had been made, as was appropriate.

People were supported by staff that were given training and were skilled enough to provide safe and effective care. People were assisted to receive health and well-being care from appropriate professionals. Staff were trained in any necessary areas so they could effectively meet people's diverse and changing needs.

Staff built relationships with people so that they were able to provide caring and compassionate support. People were encouraged to make as many decisions and choices as they could to enable them to keep as much control of their daily lives, as was possible. People were treated with kindness, dignity and respect at all times. The service had a strong culture of person centred care which recognised that people were

individuals with their own needs and preferences

The service was led by an experienced registered manager. The registered manager was described by staff as approachable and supportive. The provider and registered manager assessed and reviewed the quality of care provided. Some improvements were needed with regard to effective record keeping.

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 mainly but may not always be safe.

Areas of safety such as fire safety and stairway safety needed to be reviewed.

People were given their medicines safely.

Staff protected people from any type of abuse.

There were enough staff to make sure people were cared for safely.

Staff were checked to make sure they were safe and suitable before they were allowed to work with people. However some parts of the application forms were changed to improve the service's ability to check up on applicants.

Is the service effective?

Good

The service was effective.

People were supported and cared for by staff who had been trained to meet their needs.

People were helped to take all the necessary action to stay as healthy as possible.

Staff encouraged and supported people to make as many decisions for themselves as they could and made sure they protected their rights.

Is the service caring?

Good

The service was caring.

People were treated with kindness, respect and dignity at all times.

Staff interacted positively and patiently with people.

People were helped to stay as independent as they were able for

as long as possible.

The home had a homely atmosphere where people and staff felt comfortable.

Is the service responsive?

Good

The service was responsive.

People's needs were responded to quickly by the care staff.

Staff listened to people with regard to their daily choices and acted on their wishes.

People were recognised as individuals and were supported and cared for in the way that they preferred and that suited them best.

People were able to participate in a number of daily activities which they enjoyed.

People could make comments or complaints about their care. These were listened to and acted upon, if appropriate.

Is the service well-led?

Good

The service was well-led.

The service, generally, kept good records but some completion issues needed to be addressed.

Staff felt supported by a registered manager they were comfortable to approach.

The provider and registered manager checked the service was giving good care to people. They made changes to improve things, if they needed to.

Remyck House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. 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 took place on the 19 October 2016. It was unannounced and carried out by one inspector.

Before the inspection we looked at all the information we had collected about the service. This included all information and reports received from health and social care professionals and others. We looked at the notifications the service had sent us. A notification is information about important events which the service is required to tell us about by law.

During our inspection we observed care and support in communal areas of the home and used a method called 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 to us. Additionally, we spoke with four people who use the service, the registered manager, two care staff and relatives and friends of people who use the service. We received feedback from two health professionals and two relatives after the inspection visit.

We looked at the records, including plans of care and daily notes for six people who live in the service. In addition we looked at a sample of other records related to the running of the service. These included a sample of medicines administration record charts, four recruitment files, staff training records, duty rosters, menus and records used to measure the quality and safety of the service. The registered manager provided further information, after the day of the inspection, as we requested.

Requires Improvement

Is the service safe?

Our findings

People may not be kept as safe as they could be from the potential risk of fire and from using the stairs. The registered manager had completed the service's fire risk assessment, which contained minimal detail, in December 2015. He agreed to seek advice from the local fire service or other fire prevention professionals to ensure it was adequate to protect people from the risk of fire.

Some people used the stairs to access the first floor. There were generic and individual risk assessments for people using the stairs. The staircase had a handrail on one side of the wall which may not be suitable for use by less physically able people. The registered manager agreed to review this and seek guidance as to the best way of ensuring the stairs are as safe as possible for use by those who live in service.

We recommend that the providers seek guidance from reputable sources to enable them to take all possible action to reduce risks caused by the environment.

People, staff and visitors were, generally kept safe, whilst in the home. However, on the day of the inspection, four fire doors which had a keep shut sign on them were wedged open with chairs or wedges and two fire doors did not close properly. This posed a potential risk to people should a fire occur. The registered manager and staff team had not recognised the potential serious risk to people. The six doors noted were bedroom doors and the registered manager was not clear if they needed to be designated as fire doors. However, as they all had fire door, keep shut signs on them they should be treated as such. After the inspection the registered manager advised us that four automatic door guards (which closed when the fire alarms sounded) were on order. He told us that two doors had been adjusted to ensure they closed completely.

Staff followed health and safety policies and procedures and safe working risk assessments were in place. These included moving and handling and infection control. The registered manager told us all baths and showers had thermostatic valves fitted and the water temperature was tested before people were immersed in the bath. The service kept records of bath temperatures and the maintenance person tested water temperatures on a weekly basis. Maintenance checks to ensure the service was safe were conducted at the required intervals. These included the lift and fire equipment, legionella and gas safety. The service had a detailed contingency plan available. This covered emergencies such as a full evacuation plan, staff sickness and flood.

The safety of people and staff was improved because the service learned from accidents and incidents. Accident and incident reports recorded the incident and the immediate action taken. The service kept a falls register which had recorded 59 falls since January 2016. However, a large number of these were slides out of chairs or trips not resulting in a 'fall 'or injury. Of the 59 recorded falls one had resulted in a fracture and one in a hospitalisation. Records of falls and post fall treatments were sent to people's GPs and any underlying health issues such as infections were identified. Whilst it was evident in procedures and care plans that action had been taken to minimise the risk of recurrence, these actions were not always clearly recorded in accident and incident records. The registered manager told us they would ensure accident and incident

records included this information, in the future. A relative told us that their family member had fallen in the night and said this was dealt with properly. They told us the service had provided an alarm, changed the type of bed and provided bed sides for the person's safety.

People were given their medicines safely by staff who had been trained to administer it. People's medicines were stored in a locked medicine cupboard in locked trolleys. The temperatures of the trolleys were not checked regularly but the registered manager agreed to ensure they were kept at the correct temperatures. The service used a monitored dosage system (MDS) to assist them to administer medicines safely. MDS meant that the pharmacy prepared each dose of medicine and sealed it into packs. The medication administration records (MARs) were accurate and showed that people had received the correct amount of medicine at the right times. Two medication administration errors had been reported in the previous 12 months, these had been dealt with appropriately. One relative told us that their family member sometimes had to wait for medicines which were occasionally ordered late. However, on the day of the inspection we saw that medicine was ordered monthly, prescription copies were kept and people received their medicines as required.

Guidelines for the use of 'when required' medicines were not always available with the medicine administration paperwork. This meant they were not easily available to medicine administrators. The registered manager completed new guidelines and placed them in the medicine records rather than general care plans, on the day of the inspection. Body maps were not always in place for people who required pain relief 'patches'. This meant that care staff would not be able to identify where to put new patches and may cause the medicine to be less effective. The registered manager undertook to ensure staff used body maps when administering patches to people's skin.

People told us or indicated, by nodding or smiling, that they felt safe in the home. Comments included, "Yes I'm safe" and "Oh yes I feel safe." A relative told us they had never seen anything they were not comfortable with. Another said, "Yes, I am confident that people are safe and well treated." Professionals said no when asked if they had ever seen anything they were not comfortable with.

People were protected from abuse or harm by staff who were trained and knew how to safeguard people in their care. Safeguarding training was up-dated every year. Staff were able to describe what actions they would take if they identified any safeguarding concerns. They told us they were confident that the registered manager would respond to any concerns they had and take the appropriate action to protect people. They knew who to approach and were clear that they would report issues outside of the organisation if the necessary action was not taken. The service had reported two safeguarding concerns (during the last 12 months) to the local authority which had been dealt with appropriately.

People's safety was enhanced by the use of personalised risk assessments which were incorporated into their care plans. Any significant risks for the particular individual were identified and separate risk assessments were developed. These included falls, mobility and personal care needs. Nationally recognised risk assessment tools were used for areas such as nutritional needs and skin integrity. Care plans advised staff how to offer people care as safely as possible by considering any specific risks to them. Each individual was provided with a personal emergency evacuation plan.

People enjoyed living in a clean and hygienic home with no offensive odours. Staff were provided with protective clothing to assist people with personal care and when handling food. They changed their gloves and aprons when entering different areas of the building. An infection control audit was completed every three months. The service was awarded five star (very good) environmental food safety standards in December 2015. Relatives told us that the service was always clean and well presented.

The service ensured that people were looked after by staff who had, generally, been recruited safely. In two of the four files it was not clear what dates people had left their previous employment. This was because application forms asked candidates for a start date but not a leaving date. This meant that it was difficult to check whether there had been any gaps in work history and why people had left previous jobs. For the newest staff member we saw that this issue had been rectified with the use of new paperwork. The registered manager confirmed that this was the paperwork they would use in the future. The files showed that checks to confirm that prospective employees did not have a criminal conviction that prevented them from working with vulnerable adults, were made. References were taken up and candidates' identity was checked.

People were supported by staffing levels which were adequate to meet their needs, safely. There were a minimum four staff on the morning shift, three in the afternoon and three waking night staff. Day staff were supported by the registered manager (during the week) and a variety of ancillary staff. Staff and relatives told us there were enough staff to meet people's needs safely. One relative told us there did not appear to be as many staff around at weekends but there were still enough to keep people safe.

Good

Is the service effective?

Our findings

People were supported with their healthcare needs to enable them to stay as healthy as possible. Healthcare needs were clearly described in individual care plans. People were assisted to access health care services and received on going support from external professionals, as necessary. For example, health notes recorded visits by GPs, district nurses and psychiatrists. Professionals and relatives told us people received health care in a timely way. People said they saw the doctor whenever they felt they needed to.

People with high anxiety levels, agitation and distress were well supported. The service used behaviour forms and reviewed any distressing behaviour as it occurred. These helped staff to look for reasons as to why the behaviour had occurred and if they had supported people as effectively as possible. Care plans included detailed information to help staff to react appropriately to behaviour that may harm or distress the individual or others. The service focussed on using distraction techniques to divert people from being involved in such incidents. Staff were specifically trained in how to deal with these types of behaviours and/or incidents. Staff told us they do not use physical restraint. During recent incidents it was clear that the staff used distraction techniques which were largely effective. However, police intervention to support people with serious distress and agitation which caused possibly harmful behaviour was requested appropriately.

People's well-being needs were met. People were assisted to eat adequate amounts of food and to drink enough fluids to keep them healthy. People's care plans included nutritional and eating and drinking assessments, as necessary. Nutritional risk assessments resulted in the development of highly detailed care plans to support people to eat and drink adequately.

People were provided with food of their choice and to their taste. They were offered alternatives to the main menu if they did not want what was offered. People told us, "The food is fine." One person was complaining about their vegetables being too hard, which was resolved for them individually. We noted that this had been discussed in resident meetings and the kitchen had responded by producing softer vegetables. Other people said the vegetables were cooked exactly to their liking and requested second helpings.

People who needed support were, gently, verbally encouraged or physically helped to eat their food to ensure they ate an adequate amount. People were offered drinks and snacks throughout the day on the day of the visit. A relative told us that their family member enjoyed her food. They said, "…the food seems good and they can have what they like. Ice cream on cornflakes for instance. There are a lot of snacks and treats offered throughout the day." The dining experience was pleasant and people were not rushed to finish meals. Kitchen staff interacted with people and listened to requests for additions or alternatives to the food provided.

People's rights were upheld by staff who understood consent, mental capacity and Deprivation of Liberty Safeguards (DoLS). Staff had received Mental Capacity Act 2005 (MCA) training. The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to

do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. Care staff told us they had received MCA training and understood what action they would need to take if they noted anyone who appeared to have a deteriorating ability to make decisions.

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 application procedures for this in care homes and hospitals are called the DoLS. The service had made 21 DoLS applications as people could not leave the building independently because of safety issues. None of the DoLS applications had been agreed by the local authority at the time of the inspection.

People were supported and encouraged to make as many decisions and choices as they could. People could consent to their care or asked the service to discuss issues with their family members. If people lacked capacity best interests decisions were made by a multi-disciplinary team. At the time of the inspection one person, in the home, had a power of attorney (someone who could legally make decisions on their behalf.)

People were provided with any necessary equipment to ensure their comfort, safety and to maintain their mobility for as long as possible. They were provided with any necessary equipment such as, special beds, alarm mats and mattresses. Wheelchairs, walking frames and specific bathing equipment were provided, as required. Areas of the building had been recently refurbished and were fresh and bright. There had been some attention paid to trying to achieve a dementia friendly environment, however the registered manager was aware that more could be done in this area. For example, people living with dementia had their photographs on their doors to help them identify their rooms. However, in some long corridors, walls were devoid of suitable objects of interest or recognition. Some areas of the home had peeling paint and needed redecoration. The registered manager told us the refurbishment plan was proceeding as quickly as possible.

Staff were trained to meet people's diverse and changing needs. Staff told us they received good training opportunities. The service had a schedule of training they considered to be core and staff completed these as per the schedule. Of the 20 care staff 13 had completed a relevant health and social care qualification. Additional relevant training was completed to meet people's specific needs. These included, challenging behaviour and dementia care. A professional told us that the home participated in some external training offered but attendance could be improved.

Staff were supported to enable them to offer good care. They received one to one supervision approximately six times a year and as and when they needed it. They completed an appraisal once a year. Staff told us they felt supported by the registered manager and their colleagues. The service used the care certificate framework (which is a set of 15 standards that new health and social care workers need to complete during their induction period) as their induction tool.

Good

Is the service caring?

Our findings

People were treated with kindness by caring staff. People told us staff were kind and caring. One person said, "They're all very kind" and another said, "They seem to really care about us." One relative commented, "I have always found the staff to be kind, patient and respectful with residents…"

Staff, generally, interacted positively with people. However, during the meal time some staff did not verbally communicate very often with them. One (of three) staff member was excellent at communicating and interacting with people. They managed to speak with almost everyone in the dining area. They encouraged social 'chit chat' and stimulated people's interest. At other times of the day staff reacted to people in a kind and patient way. For example, they used appropriate tone of voice and spent time to find out what people wanted and why they were distressed or agitated. Staff treated people in a warm and friendly manner. However, it was noticeable that some staff interacted more often and effectively with people than others. The registered manager undertook to discuss this area of care with the staff team. Staff used people's preferred name and spoke with them respectfully.

Staff maintained people's privacy and dignity and were provided with training in dignity and respect. Care plans noted how staff were to help people, whilst ensuring their dignity and privacy. Staff gave examples of how they offered people personal and intimate care privately and in a dignified way. These included, closing doors and curtains, covering people with towels and asking if they needed assistance quietly and discreetly. However, it was noted that some people did not have net curtains at the windows. The registered manager told us people were always helped to close their curtains prior to addressing any personal care needs. Relatives and friends told us people were, "Treated with respect and their dignity is preserved." Another said, "They respect him, treat him with dignity, and give him privacy."

People were respected. They and their families were encouraged to make their views about the home and how it was run, known. Resident meetings were held at least four times a year and residents and relatives told us they could raise any issues with any of the staff team. Care plans were reviewed by individuals and their key worker who noted any views people had.

Staff had developed good relationships with people. They were knowledgeable about people's individual needs and personalities and were aware of people's needs, likes and dislikes. People's religious, cultural and lifestyle choices were included in their plans of care and staff respected their diversity and individuality. For example, noting someone's childhood home and discussing their memories of a different cultural upbringing, with them. A staff member told us that people's various spiritual needs were catered for by visiting ministers representing different religious beliefs. A relative commented, "All the staff seem to know all the residents very well… My [family member] has a very good relationship with most of the staff and so there is excellent mutual cooperation."

People were supported to maintain as much of their independence as they were able to, for as long as possible. How staff were to encourage people to do as much for themselves as possible was noted on plans of care. Staff encouraged people's independence by sensitively and discreetly suggesting people could do

things for themselves with the assurance that they would be offered help if needed.

People were given compassionate end of life care. People's wishes with regard to end of life care and funeral directions were noted in plans of care. Specific, detailed plans for people's end of life care were developed, when necessary, taking into account people's preferences and directions. The registered manager told us there was no-one in the home receiving end of life care, on the day of the inspection visit. They said the staff team were supported to provide appropriate care from GPs, district nurses and end of life specialists, when required. Do not attempt cardio-pulmonary resuscitation forms (DNACPR) were fully completed and signed by the GP, where appropriate.

Good

Is the service responsive?

Our findings

The service was responsive to people's needs. People told us staff were available to help them if they needed it. A relative commented, "The home is very sympathetic to resident's needs". Another said, "The staff are always responsive and respond very quickly." A professional noted that the staff were flexible and dealt well with people with specific needs.

Staff responded to people when they identified that they may need attention. They were able to interpret people's communication and respond appropriately to their needs, even when assistance was not verbally requested. People were confident to ask care staff for help or attention. Staff, mostly, responded to people's requests, in a timely way, throughout the day of the inspection visit. However, one staff member appeared to find it difficult to understand what a person was asking for. Another staff member noticed there was a problem and immediately responded to the individual.

People's needs were assessed with them, other professionals and families or friends before they moved in to the service. The assessments were developed into individualised care plans which met their specific needs. Care plans were (person centred (individualised) and included emotional well-being, communication and people's preferred routines.

People's diverse and changing needs were identified and met as plans of care were reviewed every month to ensure they were up-to-date and met people's current needs. People and their relatives or representatives were involved in planning and reviewing their care if they chose to be. Staff told us they worked very closely with families and kept them informed of any changes to people's well-being. A family member told us, "… I have good email communication with both the owner and manager and we communicate whenever necessary. If I have questions, they are always responded to promptly."

Changes to people's care recommended by external health care professionals were recorded on their health records within their plans of care. The service identified when they could no longer meet people's needs. They worked with the person, families and other professionals to try to identify a more appropriate placement. However, people moving to more suitable services was sometimes delayed because of lack of availability and occurred as a result of a crisis situation. The service sought assistance from appropriate authorities to deal with such incidents.

People told us they had organised and other activities, which they enjoyed. The service had an activities organiser who developed a programme of activities to meet people's needs and preferences. People and relatives were complimentary about the skills and attitude of this member of staff. Staff felt the home may benefit from more community involvement. A relative commented, "…one of the most important aspects of care is that residents have good social interaction, not only between each other but also with the staff, and a plentiful supply of stimulating activities in order to avoid the situation of residents feeling lonely, even though they are surrounded by other people. I believe Remyck House do their best to achieve this."

People, relatives and friends were able to comment on the way care was being offered. There was a robust

complaints procedure and recording system which recorded complaints, suggestions and compliments. One complaint had been received in 2016. This had been investigated and the outcome recorded. People and their relatives told us they knew who to talk to and would be comfortable to complain if necessary. An issue with regard to staff losing an individual's personal belongings, which cost a large amount of money to replace, was being considered by the registered manager, although no formal complaint had been made at this time.

Good

Is the service well-led?

Our findings

The registered manager of the service had been registered since 2010 but had left the service for a short while and returned during the six year period. Staff and relatives told us the provider and registered manager were, "open and approachable." One relative felt the staff were very good but there wasn't always the organisation to support staff to know what they were doing. This was not evident on the day of the inspection and was not the view of other relatives or professionals. One health professional and three relatives/friends told us they were happy that people received, "Good care."

The views of people, staff and others were listened to and taken account of. Regular resident and staff meetings were held and care plans were reviewed with people. People were able to talk to their key workers and other staff. The service held staff meetings every month and resident and relatives meetings approximately four times a year. The dates of the year's relatives meetings were displayed in the foyer of the service. The minutes of the residents meetings showed that how to complain, meals and activities were topics discussed. The actions the service needed to take from comments people made were recorded and actioned, as appropriate.

People were provided with good quality care which the provider and registered manager monitored and assessed by a variety of processes. For example, a number of audits to check on all aspects of the service were completed regularly. These included health and safety audits and reviewing care plans and complaints. A monthly management meeting was held. This involved the providers and the registered and deputy managers. Notes of the meetings were taken and included any actions the provider identified as necessary. For example, the meeting held on the 18 July 2016 resulted in a plan which noted improvements needed. These included weekly medicine administration records checks, carpets to be fixed and water testing to be completed. The dates actions were to be taken by and when they were completed was recorded.

The service sent annual surveys to people, families, friends and other professionals. Of the 28 sent to people and their families and friends, 17 were returned. The surveys were evaluated and the results were presented and discussed at the various meetings. A number of actions were taken in 2016 as a result of the various audits and quality assurance processes. These included relatives meetings being held in the evenings every three months and the replacing floor coverings which was brought forward. People chose to have carpets rather than hard flooring in corridors and to have their vegetables cooked softer than was usual.

Good quality care was supported by records, relating to people who lived in the service. People's records were mainly accurate and up-to-date but there were some that were not fully completed. For example, the service had a hair washing record for individuals. This had not been completed in care plans for the month of October. The bath and shower records had been completed and the assumption was that people had been supported to wash their hair at the same time. However, one relative told us that their family member's hair was occasionally greasy and in need of a wash and some people had greasy looking hair on the day of the inspection. This did not have a major adverse impact on people but hair washes may have been missed because of the omissions in the records. Other records were not always dated. People's records gave staff

enough information to enable them to meet people's needs safely and in the way they preferred.

Records relating to other aspects of the running of the service were mostly well - kept and up-to-date. However, some, such as maintenance repairs had not been dated. The registered manager undertook to review all records and paperwork and ensure staff understood the importance of completing them. The Care Quality Commission received appropriate notifications as required.