Review of compliance

The Redhouse Care Home The RedHouse Care Home	
Region:	South East
Location address:	2 Southampton Road Fareham Hampshire PO16 7DY
Type of service:	Care home service without nursing
Date of Publication:	August 2012
Overview of the service:	The Redhouse is a care home providing personal care for up to 36 older people who may have dementia or mental health illnesses.

Summary of our findings
for the essential standards of quality and safety

Our current overall judgement

The RedHouse Care Home was not meeting one or more essential standards. Action is needed.

The summary below describes why we carried out this review, what we found and any action required.

Why we carried out this review

We carried out this review because concerns were identified in relation to:

Outcome 04 - Care and welfare of people who use services
Outcome 05 - Meeting nutritional needs
Outcome 08 - Cleanliness and infection control
Outcome 12 - Requirements relating to workers
Outcome 13 - Staffing

How we carried out this review

We reviewed all the information we hold about this provider, carried out a visit on 12 July 2012, observed how people were being cared for, looked at records of people who use services, talked to staff and talked to people who use services.

What people told us

We spoke with 5 people who at live at the home, 10 staff, 2 visitors and a visiting healthcare professional.

Those that could express their views said they were happy living at the home. They told us that "all the carers are ever so good". People said they were able to express their views and believed staff would try to respond to their views and wishes.

People commented that the home arranged for them to see health care professionals such as General Practitioners (GP's) when they needed to.

People told us that they were able to make choices about their daily activities and routines; one said "We are our own bosses." We were told about how they were able to choose whether to join in with group activities or occupy themselves.

People told us there were always staff available to provide support and respond to call bells promptly. One person we saw tidying up the lounge said "I help out, I don't have to but I want to". They told us they had confidence that staff had the necessary skills to provide the care and support they needed.

For some people living at the home, because of their level of dementia they were unable to directly communicate their needs and views. Because of this we used the Short Observational Framework for Inspection (SOFI) in one of the lounge areas. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

Our SOFI observation showed that staff were aware of how different people expressed their decisions. This meant that people who were unable to communicate verbally were still able to express themselves and staff mostly responded to their choices.

What we found about the standards we reviewed and how well The RedHouse Care Home was meeting them

Outcome 04: People should get safe and appropriate care that meets their needs and supports their rights

The lack of detail in care plans and the current system for reviewing could mean people were at risk of sometimes not getting the appropriate care. The provider was not meeting this standard. We judged that this had a minor impact on people using the service and action was needed for this essential standard

Outcome 05: Food and drink should meet people's individual dietary needs

The lack of accurate records and poor staff communication places people using the service at risk of not receiving regular nutritious food and adequate fluids. The provider was not meeting this standard. We judged that this had a minor impact on people using the service and action was needed for this essential standard.

Outcome 08: People should be cared for in a clean environment and protected from the risk of infection

People were protected from the risk of infection because appropriate guidance had been followed. The provider was meeting this standard.

Outcome 12: People should be cared for by staff who are properly qualified and able to do their job

The provider was taking steps to ensure that people were cared for, or supported by, suitably qualified, skilled and experienced staff. The provider was meeting this standard.

Outcome 13: There should be enough members of staff to keep people safe and meet their health and welfare needs

There were enough qualified, skilled and experienced staff to meet people's needs. The provider was meeting this standard.

Actions we have asked the service to take

We have asked the provider to send us a report within 7 days of them receiving this report, setting out the action they will take. We will check to make sure that this action has been

taken.

Where we have concerns we have a range of enforcement powers we can use to protect the safety and welfare of people who use this service. When we propose to take enforcement action, our decision is open to challenge by a registered person through a variety of internal and external appeal processes. We will publish a further report on any action we have taken.

Other information

Please see previous reports for more information about previous reviews.

What we found for each essential standard of quality and safety we reviewed

The following pages detail our findings and our regulatory judgement for each essential standard and outcome that we reviewed, linked to specific regulated activities where appropriate.

We will have reached one of the following judgements for each essential standard.

Compliant means that people who use services are experiencing the outcomes relating to the essential standard.

Where we judge that a provider is non-compliant with a standard, we make a judgement about whether the impact on people who use the service (or others) is minor, moderate or major:

A minor impact means that people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

A moderate impact means that people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

A major impact means that people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly.

Where we identify compliance, no further action is taken. Where we have concerns, the most appropriate action is taken to ensure that the necessary changes are made.

More information about each of the outcomes can be found in the *Guidance about compliance: Essential standards of quality and safety*

Outcome 04:
Care and welfare of people who use services

What the outcome says

This is what people who use services should expect.

People who use services:
* Experience effective, safe and appropriate care, treatment and support that meets their needs and protects their rights.

What we found

Our judgement

The provider is non-compliant with Outcome 04: Care and welfare of people who use services. We have judged that this has a minor impact on people who use the service.

Our findings

What people who use the service experienced and told us
One visitor told us that they had been involved in the move of their parent to the home. However they had not seen or signed a plan of care detailing the support their parent would be given. Another relative told us that they had also not been involved in the plan of care for their parent who had dementia.

Other evidence
We looked at three care plans and they included risk assessments which included actions to be taken to reduce the identified risk. There were also monitoring tools in place for particular issues such as falls and changes in behaviour.

The staff told us that each person had a care plan and that they were aware of the support individuals needed but they also asked them what they needed as people sometimes changed their minds, or they asked again a little while later.

The care plans at The Redhouse had 22 areas where staff could add information about the person's individual needs such as dressing, eating and drinking. One of the care plans we saw showed the support the individual needed, how this should be offered and other treatments that were needed.

On another care plan we looked at we saw the person had been at the home for two months and only 6 areas had information for staff. When we spoke with person they had difficulty in hearing us and this was not documented in the care plan.

In some areas in the three care plans we looked at, they had basic instructions such as, 'staff to support with personal care'. There was no detail on how these should be achieved or offered to the person using the service.

Staff told us that not everyone was able to sign their care plans and they sought verbal or non verbal consent to carry out care and treatment. We saw that where a relative or advocate was involved they also had not signed the plans of care.

When people had been ill or had an accident, daily reporting records by staff showed appropriate referrals to health professionals and any action taken as a result. We saw that people had seen an optician, dentist, physiotherapist and chiropodist as needed.

This meant that although people were satisfied with their care the lack of detail in care plans and the system for reviewing was not sufficient and this could mean people were at risk of sometimes not getting the appropriate care.

Our judgement
The lack of detail in care plans and the current system for reviewing could mean people were at risk of sometimes not getting the appropriate care. The provider was not meeting this standard. We judged that this had a minor impact on people using the service and action was needed for this essential standard

Outcome 05:
Meeting nutritional needs

What the outcome says

This is what people who use services should expect.

People who use services:
* Are supported to have adequate nutrition and hydration.

What we found

Our judgement

The provider is non-compliant with Outcome 05: Meeting nutritional needs. We have judged that this has a minor impact on people who use the service.

Our findings

What people who use the service experienced and told us
We spoke with people using the service about meals and they were generally happy with the food. Comments included; "I like 'good old fashioned English food' and that is what I get here". Generally people said that the food was good was available when requested and that drinks were 'nice' and also available when people wanted them.

For some people living at the home, because of their level of dementia they were unable to directly communicate their needs and views. Because of this we used the Short Observational Framework for Inspection (SOFI) in one of the lounge areas. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

One person said "I am often still hungry", we saw later that staff had given them a bowl of ice cream. We observed that the person who told us they were 'often still hungry' had a bowl of ice cream after lunch and staff told us that was her third one. We spent 40 minutes observing lunch being served. In one dining room where seven people were able to feed themselves and two people chatted to each other. We saw staff came in to ask if people had finished and to bring the next part of the meal, other than that they did not engage with people. In the second dining area at the start of the meal there were several staff in and out of the room. Once everyone had a meal staff only came in to check when people had finished.

Other evidence
People were provided with a choice of suitable and nutritious food and drink. We asked people if they liked the meals and their response was mostly positive.

We looked at the menus and saw it was a four week cycle with some of the meals offered being very similar. On one of the days we visited, people had pork with apple and there was apple pie for dessert. On the other day it was a choice of beef curry or beef stew and sponge and custard for dessert. We asked if people did not want meat or either of these dishes what could they have. The staff had a list of likes and dislikes and people who preferred vegetarian food. On both days of our inspection the staff had made separate meals for them.

The home had a system for recording the meals offered to people and what was actually eaten by each person. These were used in conjunction with the kitchen staff in monitoring the meals and likes and dislikes of people living at the home. Staff told us they completed these records on each shift however, we found that the records were not completed for everybody. In some cases there were no records for several days in a row.

We saw that people using the service had tabards on to protect their clothing; one person had a plate guard to assist them in eating their meal. We did not see staff engage with this person or offer encouragement or support to sit and have their meal. This meant the person did not have their lunch.

Another person had been very agitated before the meal and this continued in the dining room. They disturbed other people and there were no staff to assist or divert them. This person did not sit down to have their meal which was on the table.

We asked staff if they had a record of food and fluid people had taken if staff were concerned about their health. They showed us a set of records that they used to monitor both fluid and food drunk and eaten by people where they had concerns about a persons well being. The records we saw related to the day we had observed the person's agitation, stated the person had only had food and fluid at tea time. Records for two other people also had several dates when they had declined meals and there was no record of other food being offered and taken.

We observed staff asking each other 'who' had had drinks or food in the dining room and in a bedroom we saw staff look at a record and ask the person if they had had a meal.

We looked at the stocks of food and saw there were several alternatives that staff could use if people changed their mind at the last minute about the meal that was offered.

With a lack of communication and poor record keeping people using the service were at risk of not receiving adequate food and fluids.

Our judgement
The lack of accurate records and poor staff communication places people using the service at risk of not receiving regular nutritious food and adequate fluids. The provider was not meeting this standard. We judged that this had a minor impact on people using the service and action was needed for this essential standard.

Outcome 08:
Cleanliness and infection control

What the outcome says

Providers of services comply with the requirements of regulation 12, with regard to the Code of Practice for health and adult social care on the prevention and control of infections and related guidance.

What we found

Our judgement

The provider is compliant with Outcome 08: Cleanliness and infection control

Our findings

What people who use the service experienced and told us
People said they were happy with their rooms. One person showed us their room and said "I help to keep my room tidy".

We were told that there was always clean linen and towels available and that clothes were cleaned and returned promptly

Other evidence
There were effective systems in place to reduce the risk and spread of infection. We spoke with four staff who told us that there was an infection control lead, they explained to us the home's cleaning procedures and control of infection.

The infection control lead told us that they had an infection control procedure in place in the home and that cleanliness standards were monitored to ensure they were being maintained. We saw copies of the monthly audits and weekly cleaning procedures which staff signed when completed. Staff we spoke with told us that they had completed infection control and health and safety training and had protective equipment to use such as gloves, aprons and hand gel.

All areas of the home we looked at appeared clean and with no unpleasant odours. The bathrooms that we referred to at our visit in December 2011 had been redecorated and the tiling grout renewed. Staff told us since our last visit the refuse bins for soiled items were only filled to three quarter capacity and emptied regularly.

Three members of staff we spoke with said that there have been problems with ants. We were shown the three areas, one member of staff said it was a yearly occurrence

for about a week and they dealt with it. Another member of staff said that ants had been found round the door to the home and a door in the function room. All staff said they believed the matter had been dealt with and that they had not seen any in the past couple of weeks. The provider told us that they have environmental heath and pest control out as needed in addition to their regular visits.

Our judgement
People were protected from the risk of infection because appropriate guidance had been followed. The provider was meeting this standard.

Outcome 12:
Requirements relating to workers

What the outcome says

This is what people who use services should expect.

People who use services:
* Are safe and their health and welfare needs are met by staff who are fit, appropriately qualified and are physically and mentally able to do their job.

What we found

Our judgement

The provider is compliant with Outcome 12: Requirements relating to workers

Our findings

What people who use the service experienced and told us
We spoke to people using the services but their feedback did not relate to this standard.

Other evidence
Appropriate checks were undertaken before staff began work. We saw there was a recruitment and selection process in place and the three files we looked at showed staff had undergone the necessary checks, including references and Criminal Records Bureau checks, prior to being employed. Staff we spoke with told us about their interview and the checks they knew had been carried out. They also gave examples of their induction of 'shadowing' other members of staff and the training they had received.

The manager said that seven care staff had left The Redhouse in the last six months through securing full time jobs or for health and personal reasons. They have recruited five staff to cover those hours.

Our judgement
The provider was taking steps to ensure that people were cared for, or supported by, suitably qualified, skilled and experienced staff. The provider was meeting this standard.

Outcome 13:
Staffing

What the outcome says

This is what people who use services should expect.

People who use services:
* Are safe and their health and welfare needs are met by sufficient numbers of appropriate staff.

What we found

Our judgement

The provider is compliant with Outcome 13: Staffing

Our findings

What people who use the service experienced and told us
When we spoke with people using the service they told us they thought there were enough staff at the home and that staff were always available to answer call bells and help them with care issues.

A visitor said that they thought there were enough staff for most of the day but felt staff were 'stretched at mealtimes'. Another relative told us that sometimes when they visited they did not see more than one or two staff and people using the service seemed to need help. They have had to go and find staff to assist the person they were visiting.

For some people living at the home, because of their level of dementia they were unable to directly communicate their needs and views. Because of this we used the Short Observational Framework for Inspection (SOFI) in one of the lounge areas. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We spent 40 minutes divided between the two dining areas observing the interactions between staff and people living at the home. During this period the number of staff varied. In one dining room there was little staff interaction and support as people were more able. In the other dining room at first there were four staff assisting people sit down, pouring drinks and bringing meals. For the following twenty minutes one member of staff, not always the same one, would come in and check that people were alright or if they needed anything. One person living at the home was agitated and angry and twice was seen pushing themselves against other people living at the home who

became angry. Staff did not come in to assist for three or four minutes.

At other times during our inspection we saw staff were able to make time to chat and interact with people without having to fit it around care tasks. We also saw housekeeping staff supporting people who were upset.

Other evidence
There were enough qualified, skilled and experienced staff to meet people's needs.

Duty rotas detailed that there were seven members of staff on duty during the morning until 2:00pm, five staff in the afternoon, plus the manager and at night there were three members of staff on duty.

We spoke with four members of staff, all of whom commented that there were sufficient numbers of staff on a duty at any one time to meet the needs of people living at the home. They told us this included them being able to spend some time chatting with people living at the home. Staff told us that vacant shifts caused by illness or holiday leave were covered by staff offering to do extra hours.

The manager explained that there were two staff who worked a 12 hour day, one did this once a week and divided their time between the office and care work. The other one was a member of care staff who chose to work one long day on the weekend they worked.

There were dedicated members of staff responsible for the laundry, cleaning and kitchen services. This meant that people living at the home were supported by care staff who did not have to complete non care tasks.

We spoke to a health care professional who confirmed that when ever they visited the home there were always sufficient numbers of staff to assist them and the person they were seeing.

The provider may find it useful to note that whilst there were seven members of staff available, better communication and deployment of them could be considered at mealtimes to enable support of people's needs.

Our judgement
There were enough qualified, skilled and experienced staff to meet people's needs. The provider was meeting this standard.

Action
we have asked the provider to take

Compliance actions

The table below shows the essential standards of quality and safety that **are not being met**. Action must be taken to achieve compliance.

Regulated activity	Regulation	Outcome
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 04: Care and welfare of people who use services
	How the regulation is not being met: The lack of detail in care plans and the current system for reviewing could mean people were at risk of sometimes not getting the appropriate care. The provider was not meeting this standard. We judged that this had a minor impact on people using the service and action was needed for this essential standard.	
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 05: Meeting nutritional needs
	How the regulation is not being met: The lack of accurate records and poor staff communication places people using the service at risk of not receiving regular nutritious food and adequate fluids. The provider is in breach of Regulation 14 (1) (a) (b) (c)	

The provider must send CQC a report that says what action they are going to take to achieve compliance with these essential standards.

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's report should be sent to us within 7 days of the date that the final review of

compliance report is sent to them.

Where a provider has already sent us a report about any of the above compliance actions, they do not need to include them in any new report sent to us after this review of compliance.

CQC should be informed in writing when these compliance actions are complete.

What is a review of compliance?

By law, providers of certain adult social care and health care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The Care Quality Commission (CQC) has written guidance about what people who use services should experience when providers are meeting essential standards, called *Guidance about compliance: Essential standards of quality and safety*.

CQC licenses services if they meet essential standards and will constantly monitor whether they continue to do so. We formally review services when we receive information that is of concern and as a result decide we need to check whether a service is still meeting one or more of the essential standards. We also formally review them at least every two years to check whether a service is meeting all of the essential standards in each of their locations. Our reviews include checking all available information and intelligence we hold about a provider. We may seek further information by contacting people who use services, public representative groups and organisations such as other regulators. We may also ask for further information from the provider and carry out a visit with direct observations of care.

Where we judge that providers are not meeting essential standards, we may set compliance actions or take enforcement action:

Compliance actions: These are actions a provider must take so that they **achieve** compliance with the essential standards. We ask them to send us a report that says what they will do to make sure they comply. We monitor the implementation of action plans in these reports and, if necessary, take further action to make sure that essential standards are met.

Enforcement action: These are actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers are set out in the law and mean that we can take swift, targeted action where services are failing people.

Information for the reader

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