Complete Care Services Limited

Redwood House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service: Redwood House is a residential care home that was providing accommodation and care to 7 people who have a learning disability.

People's experience of living at this home:

People told us that they liked living at Redwood House and liked some of the staff who supported them. One person talked about wishing their bedroom looked better. Another person said they were bored at weekends. Other people spoke positively about going out with staff and told us what they did. People and their relatives spoke positively about the registered manager.

Not everyone had a robust risk assessment and care plan for staff to follow in order to meet their needs and understand the risks which they faced.

Accidents and incidents were not always reviewed to ensure action had been taken to mitigate further risks. A person had had an accident and hurt themselves but a safe process had not been followed with accompanying records to ensure they were safe. No review of this incident had taken place.

People were supported to access health care services and attend routine appointments when they needed this support. Plans were put in place when the registered manager had identified when a person may not be well and in need of some input from a health professional. Although people received their medicines as the GP prescribed some safe processes were not always followed to promote people's safety in this area.

People had enough to eat and drink, but they were not being fully involved in the planning of meals. People were not offered drinks and snacks during the day. Healthy options were not promoted or offered to people. A person's cultural diet needs were not always being promoted and followed by staff.

The people at the home told us about the healthy activities they participated in. These included going to the gym to support their aims of being a healthy weight. However, some people's plans relating to this lacked information, and healthy lifestyles were not encouraged when people were in the home.

People and staff worked out goals for the year but these were not developed further. There was no

meaningful review of these and plans were not always made to try and achieve them. People spoke about their interests but there were limited attempts or plans made to help people explore these interests. Staff were not aware of what was available locally to inspire or fulfil people's interests. People's records lacked detail about these interests.

The staff were polite but task focused. They did not spend time chatting or engaging with people.

Although the home was clean it looked tired and uncared for. Basic maintenance and up keep was not taking place. The provider was not promoting the service as people's own home. There was limited stimulation and accessible information in the home and in people's rooms.

The registered manager and provider's audits were not always effective at identifying short falls, enabling lessons to be learnt and improvements to be made. There was a lack of insight and a poor culture of promoting people's rights and giving them the best of opportunities.

The home had not been fully developed and designed in line with the values that underpin the Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion. People with learning disabilities and autism using the service can live as ordinary a life as any citizen. Registering the Right Support CQC policy. Further work was needed to fully meet these values.

As a result of these findings we concluded that the service needed to make improvements and it has been rated as Requires Improvement overall with breaches of the Health and Social Care Act 2008.

Rating at last inspection: This home was rated Good overall in March 2016.

Why we inspected: This was a scheduled inspection based on a previous rating.

Follow up: We have requested an action plan from the provider which we will review. We will return to the home to check improvements have been made and sustained.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not always safe
Details are in our Safe findings below.

Requires Improvement

Is the service effective?

The service was not always effective
Details are in our Effective findings below.

Requires Improvement

Is the service caring?

The service was not always caring
Details are in our Caring findings below.

Requires Improvement

Is the service responsive?

The service was not always responsive
Details are in our Responsive findings below

Requires Improvement

Is the service well-led?

The service was not always well-led
Details are in our Well-Led findings below.

Requires Improvement

Redwood House

Detailed findings

Background to this inspection

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

Inspection team:
The inspection was completed by one Inspector and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service. They had a relative who has a learning disability.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Service and service type:
Redwood House is a care home. People in care homes receive accommodation and personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The service provides accommodation and care to up to 7 people with a range of learning disabilities and mental health needs. At the time of the inspection the service was fully occupied.

Notice of inspection:
We did not give notice. The inspection took place on 6 March 2019.

What we did:
Before the inspection we looked at the provider information report (PIR). This is information we require providers to send us at least once annually to give some key information about the service, what the service

does well and improvements they plan to make. We asked the local authorities who have placed people at the service for their views.

During the inspection we spoke with four people who lived at the home, two people's relatives; two members of staff; and the registered manager. We looked at three people's care records, three staff recruitment files, and competency records. We also looked at audits and quality assurance reports.

Requires Improvement

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm

RI: Some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed. Some legal requirements may or may not have been met.

Assessing risk, safety monitoring and management

● Accidents and incidents were not always responded to appropriately. A person had fallen and hit their head against a wooden radiator cover. An incident report had been written which stated that they should be monitored for 48 hours after this event. However, the member of staff in charge did not make contact with a medical professional to seek advice. It was recorded that they were to be monitored, but there were no accompanying records to show this person's presentation had been monitored, to enable the registered manager to have assurances that this person was safe. Following this incident there was no action taken to try and prevent this from happening again. There was no post analysis of how this situation had been handled to see if lessons could be learnt from this.

●Robust risk assessments were not consistently in place. One person did not have a full risk assessment in place with a care plan to show staff about how to manage the risks which this person faced each day. The registered manager said they were awaiting confirmation from the local authority about this person's stay being made permanent. However, they had lived at the home for some months and this person had a known history of behaviour which could harm themselves and others.

●Not all risks had been identified. There was an open pack of disposable razor blades in a bedroom and there was a raised flooring in front of a staircase. Risks assessment had not been undertaken in respect of these risks.

The above issues had the potential to have a negative impact on people's safety, therefore this has constituted a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●There was not a robust emergency plan in place to enable the service to function and support people's needs in an event which stopped the service from working.

●The registered manager ensured that various safety checks were completed relating to the risk of a fire. Fire related equipment was checked and there had been a recent positive inspection from the fire service. People's safety when using the home's transport was also being checked.

Staffing and recruitment

●Some elements of staff recruitment checks were not complete. An issue had been identified on a member of staff's Disclosure and Barring Service (DBS) check. However, this had not been risk assessed by the registered manager at the time. There was no record of how the registered manager reviewed this safety issue. The provider had not identified this shortfall in their audits and corrected this.

●Staff did not have full employment histories with any gaps to their employment explained.
Systems and processes to safeguard people from the risk of abuse

● Staff had a good understanding of what would constitute abuse and harm. However, staff were not clear the outside agencies they could also report their concerns to or how to contact the provider.

●Staff had an understanding about how they would respond to a person experiencing discrimination or a 'hate incident' when they were in town. Staff knew they could call the police and report these incidents.

Using medicines safely

● People told us that they received their medicines safely. One person described to us how they were supported to take their medicines, "Every evening staff bring it and make sure I have taken it. They just wait for me to take it."

People were receiving their medicines as prescribed. However, an in use prescribed cream did not have an open date recorded on it. One person was having a medicine when they went out to a community centre. This centre had recently told the registered manager that they no longer wanted to oversee this person taking their medicine. So, it was decided by the registered manager that this person would have this medicine on their return to the home. This was at a different time to the prescribed time. However, there had been no contact with the GP to check it was safe to do this.

Preventing and controlling infection

●The home was clean. Although there were chips in the wood work and paint which could be an infection control risk

Learning lessons when things go wrong
● There was a lack of reviewing events and considering what could potentially be learnt from these in the future for example when a person had hurt their head and when people had had epileptic seizures.

Requires Improvement

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence

RI:□The effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills and experience

● Staff were positive about their inductions and about the training they received. They gave us examples of why they thought the training was good. The registered manager was completing regular competency checks on staff. However, these did lack detail to explain how the member of staff was competent in their roles. We identified a shortfall in how staff interacted with people in the home. This was not being considered as part of these competency checks. However, the registered manager said they would correct these issues.

Supporting people to eat and drink enough to maintain a balanced diet

●People were being supported to eat enough. However, people were not always being supported or encouraged to eat healthy foods. There was no fresh fruit available to eat. One person was eating a bowl of fresh fruit, but this had been provided by their relative. When staff assisted one person with their lunch, they did not suggest anything healthy to accompany it or an alternative. One person's weight was being monitored to help them to lose weight. The plan in place lacked detail as to how they were going to achieve this. The day we inspected the home people had chosen to have a take away, when the staff talked about this with people they did not suggest any healthier alternatives or additional foods to have with this as a way to promote healthier life styles.

●Staff did not routinely ask people if they wanted a drink or a snack throughout the day.

●There was a food menu on display. However, the one on display was out of date, we told a member of staff about this and it was removed. This was not replaced by a new menu. We asked a member of staff if people at the home decided what was on the menu, they said, "I show the residents when I have done it." We saw that this menu and the menu of another person who followed a cultural diet, were not written in ways which people could easily see and understand. We were not confident that people were being fully involved in

what they ate.

●We asked staff about a person's cultural diet. They were not clear about what meant in real terms, even though they were preparing this person their food. For example, we asked what this person would eat as it was a take away night. The member of staff said, "Maybe a sausage." This person's food was also not being prepared in a way which followed the practices of this person's culture, to ensure it was kept separate from other meats. This person's cultural needs had not been fully investigated and considered here. The registered manager had not checked staff were fully aware of these needs.

Supporting people to live healthier lives, access healthcare services and support

● We were told about one person the staff were supporting to be healthier and to reduce some habits which were unhealthy. This person's relative confirmed this. Another person told us about the healthy activities they completed to try and lose weight. Although there were no planned or available healthy activities available in the home.

●We saw examples of people being supported to access health appointments when they needed this or as part of yearly check-ups. We were told by the registered manager about one person they were supporting to access health input, as they believed this person needed this, but they were reluctant to attend the appointments. The registered manager showed us the appointment scheduled that they had made to discuss this issue and try and resolve this issue, with this person's GP.

●One person told us, "If I don't feel well I tell staff and then they help me if I need to see a doctor." A person's relative told us, "I just wish our parents could see [relative] now. The last time they saw [relative] [relative] was wretched (before they moved to the home.) There is a huge improvement in [relative's] health and [relative] is happy."

Adapting service, design, decoration to meet people's needs

● A grad rail had been fitted some time ago to support a person to access the back garden.
● living spaces and people's rooms looked tired and uncared for. Rooms had not been painted for a long time, there were marks on the walls and chips in the paintwork. Two people's wardrobe doors were broken. Some items of bedroom furniture had old stains and marks on them, Little thought had been given by the registered manager and provider to promote the fact that this was individual people's own home and to take action to fully respect this fact.

Ensuring consent to care and treatment in line with law and guidance

●The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

●People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

●We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.

●Staff had a good understanding about what capacity meant and how they were to encourage people to make their own decisions and offer people choices. However, not all the staff we spoke with understood what a DoLS was about or why they may be in place for individuals.

●People had capacity assessments in place but these lacked details as to how these individual's capacity were assessed.

Requires Improvement

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect

RI:□The effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Ensuring people are well treated and supported; respecting equality and diversity

●Staff treated people equally and understood the importance of this. However, one person's diverse needs were not fully understood by the staff.

●People told us that they liked living at the home, they indicated that they liked the staff who supported them. One person said, "I like it here. No problems. I'm fine, I don't want to move. This is a nice home and I go to the pub." Another person said, "Staff are nice. I like [name and name of members of staff]."

Supporting people to express their views and be involved in making decisions about their care

●People were being involved in the planning of their care. When staff supported people about the home, this was being led by what people wanted to do themselves.

Respecting and promoting people's privacy, dignity and independence

● Staff were mostly polite to people and treated people as adults. Although one member of staff referred to someone repeatedly as "He" in front of them. Another member of staff after the person had told them about their day in a repetitive way, said, "Whatever." and walked off. We also observed throughout the day a member of staff walked around the home with two disposable gloves attached to the outside of their trousers on full view. We told the registered manager, who asked the member of staff to remove these. Staff also referred to people as residents, service users, or he.

●When we spoke with staff they told us how they promoted people's dignity and independence when they were supporting them with their personal care. Such as giving people time on their own during this process but being available to help if need be.

●A person's relative told us, "I think the staff have just the right balance and mutual respects. They speak to [relative] in a nice way, not condescending and [relative] looks on them as his friends now, although they are staff."

Requires Improvement

Our findings

Responsive – this means we looked for evidence that the service met people's needs

RI:□People's needs were not always met.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control.

●Peoples care assessments included information about people's physical needs and elements of their mental well-being. People's daily routines had been captured in detail. People's interests had been identified but these had not been explored in any real detail. One person's records stated that they liked music, but it did not say what bands or what type of music they liked. They told us this information when we spoke with them, but this had not been explored in their assessments. Peoples likes, and dislikes in terms of foods had not been explored.

●People's assessments did have people's signatures on these, but their assessments and reviews were not written in formats which they could easily follow. These records were not being routinely promoted as people's own accessible documents. At people's reviews they were not being asked how they thought the service could be improved or about their view of the staff were who supported them.

●People had goals which they identified for the year, but the staff supporting them had not considered or attempted to develop these goals. For example, one person's goals referenced Christmas, Easter and their weekly visit to a relative. But nothing else, despite the fact they spoke to us in an excited way about their interests. There was limited or no information about how staff were supporting people to achieve their goals.

●We asked people if they went out and were supported to follow their interests. One person said, "I go out a lot. Greyhound racing on a Tuesday, Wednesday I go to a pub in Luton with [Names of people at the home and a member of staff]. I go bowling. I have my music. In the summer I laid in the garden on a towel and we had a barbeque once. Another person said, "I do like living here because I go out. The cinema I really like with [name of member of staff]. I go bowling and to the pub. But I do get bored sometimes. At weekends. I

get a bit fed-up at weekends. I would prefer to go out more at weekends. I sometimes go for a drive with staff."

●People told us about the monthly meeting for people who lived at the home. We were told that in January people had said they wanted to go to a local football match. This had been arranged for March. One member of staff said, "Yes, three residents and I are going. We have the tickets now. Our first match. They had brought 4 tickets, but we informed him usually support workers were given a complimentary ticket, which helped with the cost to residents."

●We were told about another person who had an interest which staff assisted them to achieve. The registered manager told us how this was planned for once a month.

●People told us about some of the activities they would like to do, we told the registered manager about these and what was available locally for free and they made a note of this. Someone employed in the service should have a good knowledge of what is available locally which people may want to try. These options were not being offered and explored with people. Can we discuss this

●Some people's rooms had limited or no items in them to stimulate people, despite spending time in these rooms. We observed that one person had nothing in their room, personal to them, despite being at the home some months. No attempts had been made to try and make this a personal space. There was nothing in this person's care plan to explain this or to show this had been attempted.

●We observed that, except for the registered manager, that staff did not routinely engage with people. This was observed throughout our inspection. They did not chat to them or approach them to see if they were OK or wanted to do something. With one exception, one person had been offered if they wanted to watch a TV programme. They chose the TV programme and sat next to a member of staff. The member of staff did not engage with the person, even though the person often looked about the room. This member of staff was absorbed by what they were watching rather than engage with this person. We were told by a member of staff and the person themselves that they were having one to one time all day, however, the member of staff did not spend any time with the person, they did not chat or engage with them.

●Later in the day when some people returned from the community centre staff did not chat with them or ask them about their day. People sat in the lounge which was dark, as the main light which had been flashing all day had eventually stopped working. Rather than address this staff spent time in the dark room completing people's daily notes. No thought had been given to these people's experience at this time.

End of life care and support

● We were told that people had end of life plans in place. However, when we looked at these we found that these lacked details about what this meant for each person. On some occasions there was no information at all. There was no record of any conversations being had with people and their relatives about this.
Improving care quality in response to complaints or concerns

● The registered manager had a complaints process in place. This information was in a form to help people to read this. The registered manager told us that people would generally come and see them if there was a problem, and we saw people doing this during our inspection. A relative told us that an issue they had had been dealt with quickly.

Requires Improvement

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture

RI: Service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care. Some regulations may or may not have been met.

Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on their duty of candour responsibility

● The provider had not invested into the service for some time. People were living in accommodation which was clean but was not well maintained. There were marks on the walls, furniture which was broken, chips in paintwork, rooms had not been decorated for some years.

●One person had peeling paint from their ceiling, water marks on their ceiling, gaps in their plaster where it had fallen away from the wall. Where shelves had been removed in one person's room the holes had not been refilled. People's rooms looked tired, their rooms or the communal rooms downstairs had not been painted for some years. The dining room table rocked when you put minimal weight on it. The kitchen table was sticky and the wood veneer was peeling. People did not have lights which worked over their sinks in their bedroom or plugs to put into their sinks. People's bedroom furniture looked tired, chairs and furniture were stained through long term use. The carpet was thread bare in one part and the floor board was uneven near a stair case. Some people had limited or no stimulation in their bedrooms despite spending time in these rooms.

●When we spoke with the registered manager about this, they told us about a development plan to rectify the accommodation issues we had found. When we looked at this we found that this was in fact a blank template. We looked at the development plan from the previous year, this had not identified the historic issues which we had found. There was no consultation with people or real plans made to make improvements despite these physical realities. We concluded given the registered manager's responses to these issues and the lack of action, that there was no drive or insight to make these improvements and consider how people's experiences of living at the home could be better. One person told us, "If you could give me a magic wand I would have painted walls and new carpets."

●Given these issues and the issues we found in terms of staff interaction with people. How the service promoted and enabled people to fulfil and live out their interests, we could not be confident that there was a culture of delivering high quality care at the home.

●We looked at the audits which the registered manager and provider completed. We could see some quality checks were taking place and some of these were effective. However, these checks did not identify all the issues which we had found. People's opinion and experiences were not considered in a meaningful way which tested the quality of the service.

●Some systems were not effective or in place to ensure certain safety checks were up to date and taking place. For example, how accidents were managed and the fact there had not been a Legionella test for some years.

Continuous learning and improving care

● There was not a culture of continuous learning and improving the care people received. The registered manager had a recent inspection at another service and they told us of the improvements they intended to make following this. However, the provider had not learnt from lessons learnt from another service where similar themes had been identified.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

● There was a registered manager in post who was aware of their regulatory requirements. Staff received regular supervisions and feedback about their work. However, staff were not fully engaged with people, or understood that their role was to improve the quality of people's lives.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● People, staff, and people's relatives were being asked their views of the service at yearly survey's. However, people were not being asked on a regular basis in a meaningful way about how the service they received could be improved upon.

Working in partnership with others

●The registered manager told us how they worked with social services and health professionals. However, they had not considered if other organisations could be involved in supporting the service to develop and make improvements for people.

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12 HSCA 2008 (RA) Regulations 2014: Safe Care and Treatment The provider had not always ensured that care and treatment was provided in a safe way. Regulation 12 (1) and (2) (a) (b).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17 HSCA 2008 (RA) Regulations 2014: Well Led. There was a lack of robust leadership which promoted people's opportunities, experiences and always provided quality care at the home. Regulation 17 (1) and (2) (a) (b) (e)