Ruislip Care Home Limited

Ruislip Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Ruislip Nursing Home is a care home providing personal and nursing care to up to 31 people. The service provides support to older people, including people living with the experience of dementia and people receiving care at the end of their life. At the time of our inspection there were 31 people using the service, one of whom was in hospital.

People's experience of using this service and what we found
During the inspection we found risk assessments and risk mitigation plans were not always updated after an incident to reflect lessons learned and to include preventative measures.

The provider had systems in place to monitor, manage and improve service delivery and to improve the care and support provided to people. However, these were not always effective.

We made a recommendation the provider consider current guidance on infection prevention and control and take action to update their practice accordingly.

The provider had systems in place to safeguard people from the risk of abuse and staff knew how to respond to possible safeguarding concerns. Safe recruitment procedures were followed and there were enough staff to meet people's needs. Medicines were managed safely.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

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

Rating at last inspection and update
The last rating for this service was requires improvement (published 26 August 2021) and there was a breach of regulation. At this inspection we found the provider remained in breach of regulations.

Why we inspected
We carried out an unannounced focused inspection of this service on 20 May 2021. A breach of legal requirements was found regarding good governance. The provider completed an action plan after the last inspection to show what they would do and by when to improve.

We undertook this focused inspection to check they had followed their action plan and to confirm they now met legal requirements. This report only covers our findings in relation to the Key Questions Safe and Well-led which contain those requirements.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service remains requires improvement.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Ruislip Nursing Home on our website at www.cqc.org.uk.

Enforcement and Recommendations
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have identified breaches in relation to safe care and governance.

Please see the action we have told the provider to take at the end of this report.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Ruislip Nursing Home

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. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out by two inspectors and a specialist nurse advisor. After the inspection an Expert by Experience made phone calls to relatives for feedback of their experience of the service. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Ruislip Nursing Home is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Ruislip Nursing Home is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. 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.

At the time of our inspection there was a registered manager in post.

Notice of inspection

This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with four people. Some people could not speak with us and tell us of their experiences verbally, so we observed their interactions with staff. We spoke with eight members of staff including the registered manager, director, a nurse, a senior care worker, two care workers, the chef and a domestic worker.

We reviewed a range of records. This included six people's care records and medicines records. We looked at four staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.
After the inspection
We continued to seek clarification from the provider to validate evidence found and we spoke with ten relatives.

Requires Improvement

Is the service safe?

Our findings

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

At our last inspection we rated this key question requires improvement. The rating for this key question has remained requires improvement.

This meant 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.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong
• At the last inspection, and at this inspection, we found the provider had not always taken appropriate action to mitigate risks to people and others that were associated with the environment.
• The provider had made improvements to mitigate the environmental risks previously identified. However, although the provider had risk assessments in place for stairs, on the first floor there were stairs going up to the top of the building where there was a loft space with water tanks, pipes and stored items. The door to the loft was closed with a small bolt and not securely locked. There was a stair gate to stop people from accessing these stairs, but it was open, which meant people could reach the loft space.
• In the garden we saw open sheds with cleaning products and paint in them. An internal cupboard with cleaning products was also unlocked, which meant the cleaning products were accessible to people and could cause potential harm.
• During the inspection we reviewed people's risk assessments and risk management plans. We found these were not always updated to reflect recent incidents, and the risk mitigation plans were not always part of the care plans to make sure people were protected from identified risks.
• For example, the provider had risk assessments for falls in place with actions for preventative measures. However, as these actions were not specific to the individual's needs, there was a risk that they would not be effective.
• We also saw separate care plans that included safe environment, independent living, fire evacuation, moving and handling, mobility and dexterity. For one person, the care plan review stated they 'had two falls'. However there was no detail of the falls or other incidents in the care plan, which could have provided direction for what preventative action needed to be implemented to help stop it happening in the future.
• The provider showed us they had an incident and accident audit form which recorded lessons learnt, but again, these were generic and not integrated into the care plan.
• For example, records showed one person had unwitnessed falls and reported feeling dizzy on 21 July, 2 August and two falls on 17 August 2022. We could see from the incident and accident records appropriate immediate action was taken but the falls were not reflected in the risk assessments or care plan and there were no specific preventative measures in place. The lessons learned were general. For example on 21 July 2022 the lesson learnt was 'Importance of [Multi-Disciplinary Teams] approach in preventing falls' but the care plan did not provide the details of what the specific approach for the person was, and the person had two further falls in the following three weeks.
• Another person had a risk assessment for when they became agitated or verbally aggressive. On 21 July 2021 this person had been involved in an incident with two other people, but the risk assessment and care

plan were not updated to reflect this. The actions were generic. There were no pro-active actions recorded such as indicators for triggers, what the challenges may look like or strategies to avoid the person becoming agitated with others. After the incident, no preventative measures had been recorded to try and stop this happening again. Therefore, incidents and accidents were not always appropriately reviewed and people's risk management plans were not always updated following incidents so staff had up to date and relevant guidance to help prevent reoccurrences.

Systems had not been effective in assessing, monitoring and mitigating risks to the health, safety and welfare of people using the service This placed people at risk of harm. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• After the inspection, the provider emailed us photos to demonstrate they had taken action to lock the areas with cleaning materials and paint.
• Since the last inspection the provider had put external restrictors on windows to keep people safe from falling out of a window.
• Call bells in the communal toilets on both floors were in place and hanging down for safe access.
• Water temperatures were checked in people's rooms and recorded weekly by the maintenance staff.
• There were monthly staff meetings which covered various areas such as safeguarding, the Mental Capacity Act 2005 and a general discussion of current issues including training and the quality of work.
• Staff told us they were reminded by management when they needed to alter their approach and described how they were given examples to illustrate what actions they should take in each instance.
• A root cause analysis was undertaken for the COVID-19 outbreak and an infection control audit was completed which resulted in changes to improve the service.

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 MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

• We found the service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty. Any conditions related to DoLS authorisations were being met.

Preventing and controlling infection
• The provider had systems in place to manage infection prevention and control. Most areas of the home looked clean and well maintained.
• However, armchairs in the communal areas were stained. Some were also worn and had tears in the fabric. The registered manager explained that people ate in the chairs which contributed to the staining and that the home shampooed the chairs twice a month.
• However, as the chairs were cloth covered and not wipeable, shampooing had not been effective in removing the stains, and some chairs required replacing. One person said to us during the inspection, "This chair [the person was sitting in] is a little bit grubby, every so often I ask if I could clean it because it just doesn't look very good. It should be clean".

We recommend the provider consider current guidance on infection prevention and control and take action to update their practice accordingly.

• Staff received infection prevention and control training and we observed staff used and wore personal protective equipment (PPE) appropriately.
• We saw cleaning schedules including a check list for cleaning equipment such as wheelchairs. Hoists and zimmer frames were wiped down after each use.
• The provider had reviewed their procedures since the start of the COVID-19 pandemic and were working within government guidelines. This included facilitating visits for people living in the home in accordance with the current guidance. A relative commented there were "careful protocols for entry" and "COVID procedures are great".

Systems and processes to safeguard people from the risk of abuse
• The provider had policies and procedures in place to safeguard people from harm and abuse.
• People told us they felt safe at the home and said staff looked after them well. One person confirmed, "[I feel] very, very safe". Relatives also felt people were safely cared for and told us, "It is really good. [Person] is safe there. There is always a carer about".
• Staff had received safeguarding adults training, could give examples of signs of abuse and knew how to report concerns to the registered manager, the provider or an appropriate outside agency such as the local authority.
• The provider had appropriate systems for reporting and investigating suspected abuse. We saw the provider raised safeguarding concerns with CQC and the local authority as required to help protect people from further harm.

Staffing and recruitment
• The provider followed safe recruitment practices to help ensure only suitable staff were employed to care for people using the service. After being recruited, staff undertook an induction and training, so they had the required knowledge to care for people.
• Staff records contained proof of their identity, right to work in the UK, employment history, satisfactory references and a current Disclosure and Barring Services [DBS] check. A DBS is a criminal records check which employers undertake to make safer recruitment decisions.
• We observed there were enough staff to meet people's support needs on the day of the inspection. People confirmed this and said "[Staff] really are managing to see to you. They are excellent. They come and check quite regularly". One relative told us people "can easily get someone" if needed and another confirmed "There certainly seems to be enough staff for [person's] needs and there is always someone about".
• Staff told us no agency staff were used as all cover for shifts was completed by the staff team.

Using medicines safely
• Medicines were managed safely in line with national guidance and the provider had a medicines policy and procedure in place.
• Medicines were managed by staff who had received the relevant training and who underwent annual competency testing to help ensure they were administering medicines safely.
• Records we viewed were completed appropriately. Medicine administration records (MARs) contained sufficient information such as photographs and the allergies of each person to ensure safe administration of their medicines. MAR sheets were completed accurately and stocks we checked tallied with the balances recorded.
• Staff followed the guidance in place on managing as required medicines (PRN) for each person and documented the reasons why they had administered the medicines.
• There were checks of medicines and audits to identify any concerns and address any shortfalls.

Requires Improvement

Is the service well-led?

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.

At our last inspection we rated this key question requires improvement. The rating for this key question has remained requires improvement.

This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

At our last inspection we found systems and processes used to monitor the quality and safety of the service provided to people were not always operated effectively as they did not identify some of the safety issues identified during the inspection.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

• During this inspection we found the provider's quality assurance systems such as audits were not being operated effectively. This was demonstrated by the shortfalls identified during the inspection.
•Care plan audits were reviewed as specific aspects of care such as continence, pressures sores and falls and not audited as a completed care plan. Therefore, although for example, incidents including falls were audited, the risk assessments and mitigation plans were not effectively audited to ensure they had been updated after an incident to improve service delivery.
•Additionally, the provider did not use the audits to highlight patterns or trends or analyse them to identify where further mitigation could be implemented.
•Health and safety checks for the environment had not identified shortfalls in some areas of the environment. These included making the access to stairs safe, securely storing materials such as cleaning products and paint and ensuring the furniture was maintained at an acceptable level of cleanliness

Failure to operate effective systems to monitor and improve the quality of the service and mitigate risks was a repeated breach of Regulation 17 (good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• The provider had a business continuity plan that provided guidance for how to respond to events that affected the running of the service.
• The managers attended provider forums in three local authorities to network with other providers and share best practice.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
• People and their relatives indicated they were satisfied with the care provided. One relative said they "always have confidence in the people running the place" and "I feel that I could be listened to". Of the registered manager they said, "[They are] really good. [They have] been brilliant and communicative".
• Staff felt supported and said they received the training, information and support they needed to carry out their roles. They told us, "[The registered manager] is approachable and I get any training I need" and "They are very helpful".
• The registered manager told us they have an open door policy for relatives, staff and people living in the home. Relatives could meet with the registered manager for one to one discussions. They were also visible in the home and available for people if they want to speak privately.
• The provider had a suggestion box people could use to give feedback, and annual surveys were sent to people using the service, relatives and staff to hear about their experience of the service.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
• The registered manager understood their responsibility around the duty of candour and gave us examples of when they had to speak with relatives when something had gone wrong. They submitted notifications of significant events to CQC and informed other relevant agencies, such as the local safeguarding team when things went wrong.
• Records indicated they responded appropriately to any complaints or concerns received.
• People and their relatives felt they could raise concerns and consistently said the registered manager was approachable and listened. One person said, "Yes I can complain to [the registered manager]. I think [they] would listen and do something." A relative commented the registered manager is "always very genuine and cares. [They] will ring me if [the person's] needs change. Family values permeate throughout the home".

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
• People and their relatives had been asked for their views about the care provided at the home through resident and relative meetings.
• The registered manager told us they tried to accommodate everyone's individual needs to achieve good outcomes. For example, they supported people to have food from their own culture and celebrate relevant festivals. This included people from one community who participated in early morning worship before breakfast. The provider was also able to provide culturally appropriate food and staff who spoke the same language as this group of people.
• Some people were supported by advocates who could put forward views and wishes on their behalf.
• Staff spoke well about the registered manager and directors and found them supportive. Staff praised the registered manager for encouraging them to progress in their career.
• The registered manager told us they tried to show staff they valued them, so they celebrated staff birthdays as well as the birthdays of people who lived at the service.
• There were regular supervision sessions and group supervision which took the form of training sessions. For example, around infection control.
• Team meetings were held to share information and give staff the opportunity to raise any issues. Three staff handovers were held each day to help ensure staff had the most up to date information about the needs of people living in the home.

Working in partnership with others
• Records indicated the provider worked with other professionals to maintain people's wellbeing. These included the GP, dietician, speech and language therapist, diabetic nurse and tissue viability nurses.

• Where appropriate they shared information with other relevant agencies, such as the local authority, for the benefit of people who used the service.
• The managers attended provider forums in three local authorities to network with other providers and share best practice.

This section is primarily information for the provider

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 The provider had not always assessed or done all that was reasonably practicable to mitigate the risks to the safety of service users. Regulation 12 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not ensure systems were always operated effectively to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and to assess, monitor and improve the quality and safety of the service. Regulation 17 (1)