J S. Care Limited

# Richmond House

## Inspection report

Richmond House, Green Ways, Carr Lane
South Kirkby
West Yorkshire
WF9 3DB

Tel: 01977652288

Date of inspection visit:
29 February 2016

Date of publication:
12 April 2016

## 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 inspection took place on 29 February 2016 and was announced. We announced the inspection due to the service being small and to make sure someone was available for us.

Richmond House Residential Home is a care home without nursing. The care provider JS Care Limited is registered to provide accommodation for up to five people with dementia, learning disabilities or autistic spectrum disorder, mental health, older people, sensory impairment and younger adults who require personal care. The home has its own grounds with a rear garden, which is private and secure.

There was a registered manager in place who had been registered with the Care Quality Commission since 2011. 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. The registered manager was also the registered provider/owner.

Medicines were not always managed safely. Medicine Administration Records (MAR) were not always completed fully, handwritten MARs did not have two signatures and the service was not recording temperatures of the room where medicines were stored. We made a recommendation about medicines management.

People living at the service did not have Personal Emergency Evacuation Plans (PEEPs) in place. There had been no fire drills or evacuations for staff or the people who used the service.

The registered provider was not following safe recruitment procedures. Gaps in employment were not followed up and one staff member had not received their DBS at the time of inspection.

Risks to people arising from their health and support needs or the premises were assessed, and plans were in place to minimise them. A number of checks were carried out to monitor the safety of the premises. We saw safety checks and certificates that were all within the last twelve months for items that had been serviced and checked such as fire equipment and electrical safety.

Staff we spoke with understood the principles and processes of safeguarding. Staff knew how to identify

abuse and act to report it to the appropriate authority. Staff said they would be confident to whistle blow [raise concerns about the service, staff practices or provider] if the need ever arose.

Staff received training to ensure that they could appropriately support people, and all staff had completed or were about to complete the Care Certificate. The Care Certificate is a nationally recognised set of standards that health and social care workers adhere to in their daily working life.

There were sufficient staff to provide the support needed and staff knew people's needs well. Staff had regular supervisions and appraisals to monitor their performance.

Staff understood and applied the principles of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards to ensure that people's rights were protected. Care plans contained evidence of mental capacity assessments and best interest decisions.

People were supported to maintain a healthy diet, and people's dietary needs and preferences were catered for.

The service worked with external professionals to support and maintain people's health. Care plans contained evidence of regular involvement by external professionals.

Accidents and incidents were monitored each month to see if any trends were identified. At the time of our inspection the accidents and incidents were too few to identify any trends.

Staff treated people with dignity, respect and kindness. We observed people were happy with the care they received. Staff knew how to adapt their communication to have meaningful interactions with people.

We saw evidence to show the service provided people with information on advocacy services.

Care was planned and delivered in a way that responded to people's assessed needs, including any specialist needs they had. Care plans were regularly reviewed to ensure people's needs were met and relevant changes were added to care plans where needed.

People had access to a wide range of activities, internally and in the wider community.

The service had a clear complaints policy that was applied when issues arose. There was evidence of investigation of complaints and however outcomes were not documented.

Staff felt supported by the managerial staff.

The registered provider carried out regular checks to monitor and improve the quality of the service.

## 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.

Medicine records were not always completed fully. We made a recommendation about medicines management.

Risks to people were assessed and minimised, and assessments were used to plan and deliver safe care. People using the service did not have personal emergency evacuation plans (PEEPs) in place and no fire drills or evacuations had taken place.

Staff understood safeguarding issues and felt confident to raise any concerns they had.

The registered provider was not following safe recruitment procedures.

### Is the service effective?

**Good**

The service was effective.

Staff received training to ensure they could appropriately support people.

Staff received support through supervisions and appraisals, however we did not see recent records of what took place at these.

Staff understood and applied the principles of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards to ensure that people's rights were protected.

People were supported to maintain a healthy diet and remain well hydrated.

### Is the service caring?

**Good**

The service was caring.

Staff treated people with dignity, respect and kindness.

Staff knew people they cared for really well. Staff knew how to adapt their communication to have meaningful interactions with people.

The service provided people with information on advocacy services. At the time of inspection no one was using an advocate.

## Is the service responsive?

Good

The service was responsive.

Care was planned and delivered in a way that responded to people's assessed needs, including any specialist needs people had.

People had access to a wide range of activities.

The service had a clear complaints policy that was applied when issues arose.

## Is the service well-led?

Good

The service was well-led.

The registered provider monitored the quality of the service provided to ensure standards were maintained.

The registered provider sought the views of people using the service and staff to question practice and improve.

Staff said they were supported by management.

# Richmond 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 29 February 2016 and was announced. The registered provider was given 48 hours' notice because the service is small and we needed to be sure that the registered manager would be in. The inspection was undertaken by one adult social care inspector..

We reviewed the information we held about the service, including the notifications we had received from the registered provider. Notifications are changes, events or incidents the registered provider is legally obliged to inform us of, within required timescales.

The registered provider was asked to complete a provider information return [PIR] and we received this. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.
.

During the inspection we spoke with five people who lived at the service. We looked at three care plans, and Medicine Administration Records (MARs) and handover sheets. We spoke with eight members of staff, including the registered provider, area manager, assistant manager, the training manager, senior carers and care workers. We looked at three staff files, including recruitment records.

We also completed observations around the service, in communal areas and in people's rooms with their permission.

Requires Improvement

# Our findings

There were plans in place to provide a continuity of care in emergency situations. However each person did not have a personal emergency evacuation plan (PEEP). The purpose of a PEEP is to provide staff and emergency workers with the necessary information to evacuate people who cannot safely get themselves out of a building unaided during an emergency. We asked to see records of fire drills and full evacuations. The registered provider said that these had not taken place. The registered provider said that this had also been highlighted during a recent fire risk assessment. However nothing had been done about it.

We looked at how medicines were managed and found that systems were not always safe. Medicines were stored in a locked cupboard in people's bedrooms. However one person's medicines were stored in a locked cupboard in the person's bathroom. Medicines should be stored in a dry place with temperatures not exceeding 25 degrees. No temperatures were recorded to ensure medicines were stored safely. The registered provider arranged for thermometers to be purchased and for the handyman to move the medicine cupboard from the bathroom to the person's bedroom the following day.

We observed a lunchtime medicine administration for one person. The medication is administered by two members of staff to the person in the privacy of their own room. We observed both members of staff gained consent from the person to say they wanted to receive their medicine. We also observed both staff members read the MAR chart, check name, date of birth and the medicine before administration. Both staff signed the MAR chart to confirm the person had taken the medicine.

We found that handwritten MAR's were not fully completed or double signed. Care home providers should ensure that a new, hand-written medicines administration record is produced only in exceptional circumstances and is created by a member of care home staff with the training and skills for managing medicines and designated responsibility for medicines in the care home. The new record should be checked for accuracy and signed by a second trained and skilled member of staff before it is first used. For example one person had a handwritten MAR but staff had not wrote who the MAR was for. Staff had signed to say the medicines were administered even though the MAR may not have been for that person. We recommend that the service reviews and adopts the National Institute for Health and Care Excellence (NICE) guidelines on handwritten MARs.

We did not see written guidance kept with the MAR charts, for the use of "when required" (PRN) medicines. We also saw inconsistent transcription and completion of topical medicines [creams and ointments] application records to show the topical preparations people were prescribed, including the instructions for

use and the associated body maps. In addition, we saw MAR charts had gaps were staff had not signed to confirm administration and the carried forward information for counts of medicines from the previous month, was confusing. Recent medicine audits had not highlighted the concerns we raised. The registered provider and assistant manager said this would be remedied immediately.

This was a breach of regulation 12 (Safe care and treatment). The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Recruitment procedures were not in place to ensure that only suitable people were employed. Staff files contained applications forms with very limited details of employment history. The registered provider had not investigated reasons for gaps in employment. Two references were sought before staff were employed, although one reference we saw contradicted information on a person's application form. The registered provider had not investigated this. One staff member was working before the service received an official disclosure and barring service check (DBS). The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This helps employers make safer recruiting decisions and also to minimise the risk of unsuitable people from working with children and vulnerable adults. The service had received an email to say the person was not listed as someone barred from working with vulnerable adults but the email also stated this was not an official DBS check. Staff were also required to provide proof of identify and address and complete a healthcare check.

This was a breach of regulation 19 (Fit and proper persons employed). The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People who used the service could not always communicate verbally, therefore we observed staff interaction.

Risks to people were assessed and steps were taken to minimise them. Risk assessments were proportionate and included information for staff on how to reduce identified risks, whilst avoiding undue restriction. For example, individual risk assessments included measures to minimise the risk of falls whilst encouraging people to walk independently. Risk assessments were reviewed on a monthly basis to ensure that they reflected people's latest support needs. These meant that procedures were in place to monitor and address risks to people. All risk assessments had been signed by staff to say they had read and understood the risk. This meant that all staff were aware of potential risks.

Risks to people arising from the premises and environment were also monitored. Environmental and fire risk assessments had been undertaken, and where remedial action had been identified as required we saw the registered provider had carried out this action. The registered provider carried out monthly checks of the premises and equipment, including water temperatures, emergency lighting, wheelchairs and fire alarms. Required certificates in areas such as electrical testing, fire alarms gas safety and legionella were up to date. Throughout the inspection we observed all staff ensuring that areas were free of clutter and other trip hazards. Staff cleaned up spillages/accidents immediately. Where staff supported people who used mobility aids, this was done at an appropriate and safe pace. We saw that staff used personal protective equipment such as gloves and aprons where appropriate to assist with infection control, and there were stocks of these readily available.

Accidents and incidents were recorded, and these included details of where and when they occurred so that any patterns could be spotted and remedial action taken. There were too few accidents and incidents to highlight any patterns or themes. This meant that potential risks to people's safety in the premises were assessed, managed and reviewed.

Staff understood safeguarding issues and the types of abuse that might occur in care settings, and procedures were in place to deal with them effectively. There was a safeguarding policy in place and staff were able to describe the types of abuse they looked out for and what they would do if they had any concerns. One said, "I would not like to see any of that [abuse] going on and would report it straight away." Another staff member said, "I know about whistleblowing [telling someone] and would feel comfortable doing it if I had to." Where incidents had occurred, there was evidence that they had been investigated and remedial action taken. This meant procedures were in place to address safeguarding issues if they arose.

There were sufficient numbers of staff to meet people's needs. There was one senior care worker and two care staff plus the assistant manager throughout the day until 10pm then one waking member of staff plus one staff member on call during the night. If needed, extra staff could be scheduled at short notice from the registered provider's other services. Extra staff were also scheduled to work if a person who used the service had an appointment for example.

Good

# Our findings

All staff, whether they had just started or had been there for years, had completed or had nearly completed the care certificate. The Care Certificate sets out learning outcomes, competences and standards of care that are expected. All staff except, two new starters, had completed training in Management of Actual or Potential Aggression [MAPA]. MAPA training teaches management and intervention techniques to cope with escalating behaviour in a professional and safe manner. Staff explained how and when this is put into practice. However, one staff member said, "We hardly need to use it now because we can remove triggers before the behaviours escalate." Another staff member said, "Restraint is the very last option, now if we see a person [who used the service] is in danger to themselves or someone else, voice alone stops this, we talk to them, hold their hands etc. and they calm down." Staff had also received training in epilepsy and autism awareness.

Staff received regular supervisions and appraisals. Supervision is a process, usually a meeting, by which an organisation provides guidance and support to staff. One staff member said, "The supervisions are very useful, I received great support through these when I was promoted to senior."

Staff received a thorough induction when starting work at Richmond House. New staff completed 40 hours of observations and shadowing. The 40 hours were not part of the staff rota. One new member of staff said, "The first few days I was shown round and provided with the policies and procedures." New staff were given time to read care plans. The new staff member said, "I have read the care plans and find them informative, although I have been advised to read them again in four weeks, I was told I would understand them better." The new staff member said management and staff had been very informative.

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 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 Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. Records showed that assessments had been undertaken to check whether people's care plan would amount to a deprivation of the person's liberty

and it was deemed necessary for a written application to be submitted to the local authority for a DoLS authorisation. The registered provider kept a central record of people who were subject to DoLS authorisations, any conditions attached to them and the expiry date. This meant a clear record was in place where people had been deprived of their liberty to receive care and treatment. At the time of our inspection four people had a DoLS authorisation in place.

Where necessary, assessments had been undertaken of people's capacity to make particular decisions and if it had been deemed that people did not have capacity. We saw a record of best interest decisions which involved people's family and staff at the home when the person lacked capacity to make certain decisions. This meant that the person's rights to make particular decisions had been upheld and their freedom to make decisions maximised, as unnecessary restrictions had not been placed on them.

Staff had a working knowledge of the MCA and were able to describe how they applied its principles when supporting people. One member of staff said, "We have to assume that everyone has capacity until something like a diagnosis says they have not, they will then have an assessment to check their capacity."

We saw evidence of signed consent in people's care files. For example consent to keep personal information People were signing or putting a mark of consent to show they had understood something a staff member had told them.

No one living at the service was subject to a special diet. However one person needed their food cut up into small pieces due to a risk of choking.  Most people choose to eat in the kitchen at mealtimes although people had the option to sit where they wanted. We observed a lunch time meal and evening meal and people looked like they were enjoying the food. At lunchtime there was a choice of sandwiches, soup, jacket potato or anything else of their choosing. For the evening meal people had smoked haddock, new potatoes and vegetable. One person we spoke with said, "The food is nice." Another person grinned and nodded their head to say they were enjoying it. Staff explained how people could have a choice, if they did not like what was on offer they would suggest other meals or look in the fridge or freezer together to choose. People who used the service chose their own menu by picking from picture cards. One person who used the service explained that their favourite food was sprouts and they liked lasagne with garlic bread.

People were supported to access external services to maintain and promote their health and wellbeing. People's care records showed details of appointments and visits by healthcare and social professionals and we saw evidence staff had worked with various agencies and made sure people accessed other services in cases of emergency, or when people's needs had changed, for example General Practitioners (GPs), district nurses, dietician, chiropodists, dentists and the speech and language team (SALT). Care plans reflected the advice and guidance provided by external health and social care professionals.

Good

# Our findings

People were treated with dignity and respect. Staff spoke with people in a familiar and relaxed but professional way. Staff knocked on people's doors and waiting for a response before entering their rooms. When people indicated that they required support, staff approached them and asked how they could help in a discreet and private way that helped to maintain the person's confidentiality. One staff member said, "If someone is upset or anxious we always suggest going into their room for a chat."

Staff we spoke with said, "We are like one big family." Another staff member said, "As soon as I entered Richmond House I liked the feel of the place, it felt homely."

From observation we saw people were very comfortable with the staff. There was lots of laughter and one person who used the service was pointing and laughing at a member of staffs drawing, indicating to other staff to have a look.

One person who used the service said, "I am happy here." The service had a cat which one person who used the service had taken under their wing. They like to write about the cat and said, "The cat can be very naughty." And "I am writing about the Lily [the cat] and her behaviours."

Staff knew people really well. They knew people's preferred preferences, likes and dislikes. Staff could easily explain one person's morning routines. Another staff member also explained how one person always had to have a certain item with them, they explained this was a source of comfort but could also be reason to cause upset. For example, if the item was not where they had put them or if the item had been changed in anyway. We saw evidence in the care plan to say where the most likely place for the item to be if they had gone missing and a check list to check if the item had changed.

We saw that staff were respectful and called people by their preferred names. Staff were patient when speaking with people and took time to make sure that people understood what was being said. We saw that staff were affectionate with people and provided them with the support they needed. We saw that staff explained what they were doing and were encouraging and chatty. Staff made sure that people were safe and comfortable.

Staff clearly cared for people and prompted people to carry out tasks for themselves to maintain and increase their level of independence. People were encouraged to help prepare meals, clean up and to tidy their rooms.

Staff treated people with dignity and respect. Staff were attentive to people who used the service. We asked staff how they promote privacy and dignity. One staff member said, "When providing or supporting with personal care we shut the curtains and doors. We always ask their preference, we have one person who needs support but then we have to go and sit in their room, another person likes you to stay."

Nobody was using an advocate at the time of the inspection. Advocates help to ensure that people's views and preferences are heard. The registered provider said, "Advocates were used when best interest meetings and MCA capacity tests took place."

Good

# Our findings

Care was planned and delivered in way that responded to people's assessed needs. Records confirmed that pre-admission assessments were carried out to assess people's needs before they moved into the service. This ensured that staff could meet people's needs and that the home had the necessary equipment sourced to ensure their safety and comfort. Following an initial assessment, care plans were developed detailing people's care and support needs to ensure personalised care was provided.

A personal care plan for people's individual daily needs such as mobility, personal hygiene, nutrition and health needs was written using the results of the risk assessment. Staff knew the individual care and support needs of people as they provided day to day support, and this was reflected in people's care plans. Care plans gave staff specific information about how the person's needs were to be met and gave instructions for frequency of interventions and what staff needed to do to deliver the care in the way the person wanted. For example, one person's care plan identified the person would become anxious just before the evening meal, staff were to take the person for a walk and come back straight into the kitchen. The care plans were regularly reviewed to ensure people's needs were met and relevant changes were added to care plans where needed.

People with specialist support needs had specific care plans in place to allow staff to support them. This included schizophrenia, osteoporosis and skin disorders. For example, one person's skin disorder support plan provided information on the person's creams, how to apply them, how to cut the person's nails to prevent scratching and to promote the use of soft cotton gloves at bedtime.

Daily records were kept separately in a book for each person to be discussed at handover; along with the handover book. The daily records were completed three times a day and included significant events such as attended appointments with included the outcome of the appointment and important notices such as medicine changes. We found the daily records to be more person centred than the care plans as they included a photograph of the person along with a brief life history in picture format. Person-centred planning is a way of helping someone to plan their life and support, focusing on what's important to the person.

People had access to a range of activities. Some people who used the service attended a day centre three or four days each week. At other times, people liked to relax in their rooms, play the piano or guitar, do puzzles, draw or play darts. The service had their own van and often went out on day trips. The weekend before inspection they had been to the Wonkey Donkey Sanctuary and a museum at York. We were told they often

go to the coast for a picnic and if someone did not want to go and alternative would be offered to that person.

One staff member said they were trialling a two week activity programme which included everyone's preferred activities. The staff member said, "It offers choice, a couple of people love bowling but a couple don't so there would be an alternative for them." The registered provider also explained they have lots of parties for people's birthdays and Christmas etc.

The registered provider said, "We have set up a social event at a local pub, we have a disco or a singer and food. All the people living at all three services in our group attend. It is nice to see people build relationships with other people."

There was a complaints policy in place. This contained details of how complaints would be investigated, time frames for dealing with them and contact details for external bodies people could contact if they were not satisfied with the outcome. The service had received one complaint in the last year. This was from a neighbour regarding some trees that needed cutting down and the noise level. There was evidence of investigation of the complaint, however outcomes were not documented. The registered provider said they would add the outcome straight away.

We asked how the service managed the transition for people who came to Richmond House from their previous home. The registered provider explained that the last person joined them last year, 2015. The registered provider explained they had a one month plan, Richmond House staff went and shadowed staff were the person originally lived. Richmond House staff then took the lead and assisted with morning or evening routines. It was decided that the person should not come to Richmond House for short stays or for meals as this may cause confusion. They made sure the person built up a relationship with Richmond House staff and these staff were on duty when the person moved in. The person's social worker also provided support. The registered provider said, "The transition went really well, they settled in straight away. When they first came they were on build up drinks and struggled with personal hygiene, now this person eats regular meals and looks clean and tidy, we are so proud of them."

Good

# Our findings

At the time of our inspection the service had a registered manager who had been registered with the Care Quality Commission since 2011. The registered manager was also the registered provider/owner.

Staff told us that they felt supported by the manager. One said, "I am well supported by management. They are also on call and if we need them they come straight away." And "Any concerns are always dealt with." Another person said, "[Assistant manager's name] always helps out, we all assist each other." Another staff member said, "We all work well as a team, the service users come first and the staff to be honest."

The registered provider carried out a number of daily, weekly and monthly quality assurance checks. Quality assurance and governance processes are systems that help providers to assess the safety and quality of their services, ensuring they provide people with a good service and meet appropriate quality standards and legal obligations. These included checks of any accidents and safeguarding incidents, environmental checks, care observations and care plan audits. Where remedial action was needed an action plan was not always produced but issues were addressed. For example, we saw that an infection control audit had highlighted the need for more washable surfaces in a person's room. There was no action plan to say who was responsible for this or when it should be done by. However we saw evidence that the washable surfaces were now in place.

We saw evidence to show the registered provider sought feedback from people who used the service. This was done quarterly via a customer questionnaire. We found that the questionnaires were very complimentary and had all ticked either good or very good. The registered provider also carried out food survey's to see if people were still happy with the menus or if anything needed to be added or removed.

Staff also completed a satisfaction survey. They had received 12 back and all had ticked good or excellent. One comment throughout was the difficulty in keeping one person's room clean. We could see this had been resolved with the installation of plastic cleanable wall cladding.

We saw evidence of meetings taking place for both staff and people who used the service. The registered provider said that meetings for people who used the service were mainly one to one as they found this worked better. During these meetings people sat with staff and stated what activities they would like to attend such as one person wanted to go to the local fair. Topics discussed at staff meetings were care plans, checklists, medication, food and menus.

The registered provider carried out quarterly staff management review meetings where they would discuss training needs, the teams and and updates and service satisfaction reviews. For the service satisfaction reviews the registered provider would check the general appearance of the environment, meals, staff and the appearance of people who used the service.

The law requires providers send notifications of changes, events or incidents at the home to the Care Quality Commission and they had complied with this regulation.

# 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 did not take formal enforcement action at this stage. 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<br><br>People did not have a personal emergency evacuation plan in place, fire drills and full evacuation practice did not take place. Medicines were not managed safely. The registered provider did not carry out safe recruitment practices. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed<br><br>The registered provider had not investigated reasons for gaps in employment and one member of staff was working before the service received an official disclosure and barring service check. |