Richmond Residential Care Limited

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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?	Good
Is the service responsive?	Requires improvement
Is the service well-led?	Requires improvement

Overall summary

This inspection took place on 30 October 2015 and was unannounced.

The service is registered to provide residential care for up to 40 older people. At the time of our inspection 27 people were using the service, including some people living with dementia.

There was a registered manager in place at Richmond Residential Care Home at the time of our inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People were not fully protected from the risks associated with medicines as procedures designed to reduce risks to people were not followed and sufficient stocks of

Summary of findings

medicine were not always available. We also found individual risks associated with people's care and support were not always identified in care plans and risk assessments.

In addition, care plans did not always reflect the care and treatment people needed, and where care plans were accurate, staff did not always follow them. This resulted in people not always receiving the responsive and personalised care they required.

When people lacked the capacity to consent to their care and treatment we found that decisions had not been taken in line with the Mental Capacity Act (MCA) 2005. Information about people's day to day needs was not always recorded and used effectively to update staff as to any changes in people's care and treatment.

Systems to check on the quality and safety of service provided had not yet been fully embedded, and had not identified all shortfalls in the service. Care plans and other records associated with the service were available, however, sometimes not all records were kept confidentially.

People had their views and choices respected and were included in making decisions about their care and support. People knew how to raise concerns, suggestions and complaints. People could take part in organised afternoon activities and some people could pursue their own interests. However, when the activities coordinator was not present, people experienced varying levels of engagement and stimulation because staff members varied in how much they engaged people in everyday conversation

People received care and support from staff who showed respect for people's privacy and dignity. Overall, the staff team's approach to people was caring. Staff received support, supervision and training to help them understand the needs of people using the service. People enjoyed their meals and choices of food and drink were provided which met their dietary requirements. People's health care needs were supported by other professionals when required.

Sufficient numbers of staff were available, however at certain times of the day they were not always effectively deployed to meet people's needs. Staff were aware of how to raise concerns to keep people safe and staff working at the service had been subject to pre-employment checks that helped ensure they were suitable to work there.

The registered manager had an open and approachable management style. The registered manager was coordinating a number of improvements planned for the service, including updating furnishings as well as management and information systems.

Summary of findings

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 safe.

Improvements were needed to ensure medicines were managed safely, in addition individual risks to people were not always identified and managed.

Sufficient staff were available, however at times they were not always effectively deployed. People felt safe and arrangements were in place to ensure staff working at the service were suitable to do so.

Requires improvement

Is the service effective?
The service was not effective.

Thorough assessments of a person's capacity to consent to decisions about their care had not been undertaken. Communication and information used by staff about people's changing needs required improvement. People enjoyed their meals which met their dietary requirements and had access to other healthcare professionals as required.

Requires improvement

Is the service caring?
The service was caring.

Staff treated people with care and respect and promoted their dignity and privacy. People were supported to express their choices and views and these were listened to and respected by staff.

Good

Is the service responsive?
The service was not responsive.

People did not always receive the care required to meet their individual needs. People had opportunities to contribute their views and knew how to make a complaint or suggestion. People's ideas for the development of their interests and hobbies were also considered.

Requires improvement

Is the service well-led?
The service was not consistently well-led.

Systems to check on the quality and safety of service provided had not yet been fully embedded, and had not identified all shortfalls in the service. The registered manager demonstrated an open and approachable management style and understood their responsibilities.

Requires improvement

Richmond Residential Care Limited

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 was unannounced and took place on 30 October 2015. The inspection team included two inspectors and an expert by experience, with experience of caring for an older person. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before our inspection we reviewed relevant information, including notifications sent to us by the provider. Notifications are changes, events or incidents that providers must tell us about. We also spoke with representatives from the local authority.

We spoke with six people who used the service. We also completed a Short Observational Framework (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. During the inspection we also spoke with two relatives of people who used the service. We spoke with four members of staff, as well as the registered manager. We looked at four people's care plans and we reviewed other records relating to the care people received and how the home was managed. This included some of the provider's checks on the quality and safety of people's care, staff training and recruitment records. We also spoke with two social care professionals.

Requires improvement

Is the service safe?

Our findings

Procedures designed to help ensure the safe management of people's medicines were not being followed. We found the staff member responsible for administering medicines had not stayed with a person to ensure they took their medicines as prescribed. The person was sat at a table with two other people and their medicines had been left out on the table. In addition, we found a medicine tablet on the floor under another person's chair. The medicines administration record (MAR) chart had already been signed by the administrator to confirm the person had taken their medicines. The person had not taken their medicines. Staff told us medicines were usually left with some people, however the care plan for this person stated the person required staff to administer their medicines. The provider's medicine policy stated that staff should remain with people during the medicines administration process to reduce the chance of errors occurring and that the MAR chart should be updated only after administration of medicines. People were not being protected from the risks associated with medicines as staff were not following the correct procedures designed to reduce medicines errors.

In addition we found that one person had not received their medicines as prescribed for three days. Staff we spoke with confirmed this was because the service had not kept their medicines in stock. Staff we spoke with confirmed this person required pain relieving medicines because they were experiencing pain as well as other medicines to help manage existing health conditions. This meant people did not receive the benefits of prescribed medicines to help them manage pain levels and health conditions because staff had not ensured an adequate supply of their medicines.

We also found that the provider's policy to administer covert medicines was not being followed. Covert medicine involves administering medicines in disguised form, for example in food and drink, where a person is refusing treatment necessary for their physical or mental health. We found one person's medicines were crushed and mixed with juice. The covert medicines policy stated a care plan and risk assessment would be needed. In addition, a pharmacist would need to be involved to ensure that crushing or mixing medicines with certain food or drink was safe to do so. We saw that neither a care plan or risk assessment had been put in place and pharmacist advice had not been obtained. Staff told us they administered this person's medicines by crushing them and mixing with juice. People were not protected from the risks associated with medicines as procedures designed to reduce risks had not been followed.

We found that the administration records made by staff for medicines subject to additional controls were not accurate. We found staff had incorrectly recorded the wrong amount of medicines received and held in stock. We also found that staff had not recorded in a separate register when certain medicines had been administered. This also meant that staff had not recorded a second staff signature to confirm the administration of this type of medicine. The protocols for managing medicines subject to additional controls were not being followed and we could not be assured that they were being managed and administered appropriately.

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

People were not always protected from risks associated with their care and support because care plans did not always reflect people's care needs or identify risks to people accurately. In addition, where care plans did identify people's needs they were not always followed by staff. For example, one person was required to use pressure relieving equipment to minimise risks to their skin. Their care plan stated staff were to check their skin daily for any signs of developing risk. Staff were not recording whether this had been done. At the time of our inspection, although the person was using pressure relieving equipment they were also experiencing additional risks to their skin. There was no updated risk assessment in place to manage the additional risks to this person's skin. This meant that we were not assured that the risks to this person were being managed.

In addition, the registered manager told us one person always required a rotunda when being assisted from a wheelchair to a chair. This was not included in the person's care plan. We observed staff attempting to support this person using a frame instead of a rotunda which the person was unable to do resulting in them having to sit back down quite heavily and quickly in their wheelchair. The staff member then offered support with a rotunda which was successful. The staff member was unaware that this person's needs had changed because a new updated care plan had not been communicated to them. We saw

Is the service safe?

another person had a specific health condition, however there was no specific care plan in place to advise staff of this person's condition and what signs may indicate any deterioration that would require further specific interventions.

We spoke with one person who was spending time in their room. We found their nurse call bell did not have a very long chord and did not reach to where the person was sitting. We asked them how they felt about the call bell being out of reach and they told us, "Sometimes I try and pull the quilt over and try and get it that way, sometimes I shout." We asked the registered manager what was in this person's care plan and they confirmed that it stated they had access to a call bell when spending time alone in their room. This was clearly not the case and the registered manager agreed to take action to ensure this person could use the nurse call bell when spending time alone in their room.

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

Some people required their medicines to be administered when they needed them, rather than at specific times of day. We observed one person requested some specific medicine and staff provided this quickly for them. At the time of our inspection the registered manager was in the process of developing individual guidelines on when people needed their medicines. These guidelines would help staff administer this type of medicine consistently and at times when people need them.

People we spoke with told us staff were always available, both in the day and at night. One person told us, "I have a buzzer and they always come, eventually." During our inspection we observed staff responded in a timely manner to buzzer calls. The registered manager told us an additional member of staff helped assist people in the morning and at tea time, however we observed that at other busy times, such as lunchtimes, not all people received timely support. We observed one member of staff supporting a person with their meal in the lounge, and at the same time also trying to prompt another person to eat their lunch. One person we spoke with told us, "The home could do with more [staff]." Staff we spoke with told us the main lounge area should always have a staff member present to monitor people's safety, as some people were at risk of falls. However, we saw on several occasions throughout the day that the main sitting room was unattended by staff. The manager used a staffing dependency tool to determine the numbers of staff required to meet people's needs. We could see the manager had provided staff in addition to the numbers indicated by the staffing tool as being required. These arrangements meant that although sufficient numbers of staff were provided, they were not always effectively deployed at certain times of the day.

Staff told us they were confident to report an accident or incident and records confirmed this. We saw that the registered manager had reviewed these records in order to identify, where possible any further steps that should be taken to mitigate risks to people. People had personal emergency evacuation plans in place, however not all of these detailed the location of their bedroom and the evacuation codes on people's bedroom doors were not current. The registered manager informed us she was reviewing people's personal emergency evacuation plans. We saw that fire alarms were tested and that a business continuity plan was in place. This contained contact numbers for staff and utility services should there be an emergency, such as a power failure. Plans were in place, with some others in progress, to help manage an emergency should there be one.

People we spoke with told us they felt safe during both the day and night at the service. Families we spoke with also shared this view. One family member told us, "My [relative] is a lot safer here, I have not had any issues." We saw staff received training in safeguarding and staff we spoke with knew how to respond if they suspected someone was at risk of harm. We saw people also had safeguarding care plans in place that prompted the identification of any potential indicators of abuse. Staff recruitment files showed that staff employed at the service had been subject to pre-employment checks. These helped to ensure staff were suitable to work with people using the service. The provider had taken steps to reduce the risk of abuse to people using the service.

Requires improvement

Is the service effective?

Our findings

At this inspection, we were aware a decision had been made to administer a person's medicine to them covertly and that the person concerned was not able to consent to the decision in question. However, we found this decision had not been taken in line with the Mental Capacity Act (MCA) 2005, nor did it follow the provider's policy in place for authorising this particular decision. The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. There was no assessment recorded of the person's capacity to make the decision in question, and there was no meeting recorded, involving any appropriate representation for the person concerned, to lawfully ascertain that the care and treatment was in the person's best interests. This meant that the service had failed to follow the MCA guidance with regards to this particular decision to ensure this person's legal rights were upheld.

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). The registered manager told us no one at the service required a DoLS authorisation to be in place at the time of our inspection. The provider's policies on DoLS were not up to date and the registered manager confirmed policies and procedures were currently being reviewed and updated.

Some staff told us they felt communication between the staff team could be more effective. They told us they did not always have access to the written daily logs when they first started their shift, and that the communication book contained very little information. When we reviewed these we found the records were not very detailed and on some days, daily log sheets had not reported on each individual person living at the home. We discussed communication with the registered manager and asked about staff meetings. The registered manager told us staff meetings had not previously been held, however they had just been introduced in order to try and improve opportunities for staff to make suggestions and to improve communication between the staff team.

People we spoke with told us they felt supported by staff that understood their needs. Staff told us they felt well supported by their colleagues and the registered manager. Staff told us, and records confirmed, they had supervision and appraisal to help develop their skills and practice. We also saw staff received training in areas relevant to the care needs of people living at the service, for example, dementia care. Staff were being supported to develop their skills and knowledge to provide care and support to people using the service.

We observed people enjoyed their lunchtime meal and their hot drinks with biscuits and cake in the afternoon. One person told us, "Meal times are okay, not bad." We saw that staff noticed when people did not seem appetized by their meal and they offered an alternative. We saw this worked effectively for one person and when we checked if they had enjoyed the alternative, they told us, "Yes, it was lovely." We saw staff supported people who needed assistance with their meals, and that risk assessments were in place to help identify people at risk of malnutrition. We saw staff monitored people's weight and involved other professional experts in people's care as appropriate, such as dieticians. People were supported to receive sufficient food and drink of their choosing.

We saw other health care professionals were involved in people's care as appropriate, these included GP's and when needed, District Nurses. Social care professionals we spoke with told us referrals for specific areas of support and care to meet people's needs were made in a timely and appropriate way. This meant people received appropriate care and support for their health and care needs.

Good

Is the service caring?

Our findings

All the people we spoke with told us staff treated them with respect and that staff were caring. One person told us, “I am happy here.” One family member we spoke with told us the care provided was, “Highly recommended,” and that staff were, “Always there.” One member of staff we spoke with told us, “The residents always come first to me.” Other professionals spoke highly of the staff team at the service saying, “Staff go above and beyond,” and, “Staff are very caring.” We observed that staff knew people well and talked to them about their lives. Interactions we observed between staff and people using the service were mostly caring and respectful. Overall, people were supported by staff that were caring.

People were asked their views about their care and treatment. One person told us they felt included in any decisions. We heard staff asking people where they would like to sit, and what they could do to make them more comfortable. Other professionals told us people took an active role as part of a residents’ committee. One professional told us that the wishes of a person had recently been advocated by a family member and these had been incorporated into the person’s care plan. This helped to prevent a deterioration in the person’s condition. Records also showed people were involved in decisions about their care. The service was supporting people to express their wishes for their care and treatment.

People we spoke with told us they felt staff treated them with respect. A social care professional we spoke with told us staff were, “Very polite.” We found that staff took care to protect people’s clothing during lunchtime so that people’s clothing remained smart and clean. We observed staff worked in ways to promote people’s dignity by ensuring doors were closed when assisting people with personal care. We also saw that staff responded quickly to any requests people made to be assisted to the toilet. The service provided care and support in a way that promoted people’s dignity and respected their privacy.

Requires improvement

Is the service responsive?

Our findings

People did not always receive personalised and responsive care. This was because care plans did not always reflect people's needs. We saw staff supported people who needed assistance with their meals, however we observed one person repeatedly fell to sleep while eating their dinner. We discussed this person's care and support needs with the manager. They told us staff had found particular ways of supporting this person to eat that were effective, however these were not in the care plan and were not being followed on the day of our inspection. People did not always benefit from care and support that was personalised and responsive to their needs.

However, we also found areas where people did receive responsive and personalised care. Other professionals we spoke with told us sensor mats that alerted staff when people got up out of bed were in place for people that needed them. During the day of our inspection we also saw staff quickly responding to people's requests for assistance.

One person we spoke with told us they felt included in decisions and we saw people had been involved in a recent meeting to help plan activities and develop interests and hobbies for people. We could see people had requested support to enjoy walks outside the home and the activities coordinator told us they were arranging for this to happen. People had chosen the film to watch at a recent movie night and people were involved in other plans to hold a Christmas fayre and invite members of the local community. People were involved in planning activities and events.

On the day of our inspection the activities coordinator was available in the afternoon and asked people what they would like to do. We could see people enjoyed being supported with the afternoon's activity that was fun and enjoyable for people. We saw other people were happy reading books in their own rooms and had plenty of books to choose from. However, at other times of the day, when the activities coordinator was not present, people in the communal areas of the home received a varying amount of support from staff to engage in conversations or interests. We observed some, but not all staff took opportunities to engage people in interesting conversations to stimulate them. We observed that for some people they spent the morning passively watching television or other people and falling asleep. People experienced varying levels of support to maintain interests and hobbies.

One person we spoke with told us they knew how to make complaints and would escalate them to the highest level if needed. We found information on how to complain was available for people and records showed that any concerns raised by people had been recorded and investigated. Other professionals we spoke with told us they had been asked their views on recent visits and told us the registered manager responded quickly to any suggestions regarding people's care. We saw the results of a recent survey of relatives' views had been analysed. The results were very positive and included, "I have no complaints about the home. My relative is able to tell me about any concerns [they] have," and, "If I had any concerns I need only talk to the staff." Procedures were in place and followed, to ensure any concerns were dealt with.

Requires improvement

Is the service well-led?

Our findings

Regular checks on the safety and quality of the services provided were currently being developed. We saw a new audit had been introduced to monitor and improve practices regarding the prevention and control of infections, another had been introduced to ensure medicines administration was recorded appropriately. Other audits to identify general and specific risks had been developed and were due to be implemented imminently. We saw that systems such as fire alarms and emergency lighting were tested regularly and equipment had been serviced. Quality assurance systems were in place, and others were being developed, however, these were not always effective as the registered manager had not identified shortfalls in medicines practices. They had also not identified when policies and procedures were out of date, for example, staff recruitment and the deprivation of liberty safeguards had not been updated with the most recent changes. We also spoke to the registered manager about identifying when 'Do not attempt resuscitation' arrangements in place for people may not be valid. Systems to check on the quality of care provided were not always effective.

The registered manager was able to provide us with the records we requested during our inspection. Other professionals also told us that information was made available and was up to date when they attended meetings to review people's care. Although we saw staff could access information on people's care plans, staff had differing views on how easy it was to access them on the computer. When we discussed the computerised care planning system with the registered manager we found it took up a proportionately large amount of their time to update care plans. They told us they were looking at ways to improve the care plan recording so that care staff could more easily contribute to the process. We also found some paper based care plans had been left unattended by staff on the sitting room table. Although systems were in place to manage people's care records, not all staff found them easy to access and records were not always kept confidential.

Richmond Residential Care Home is required to have a registered manager and this requirement was being met. The registered manager understood their responsibilities and had sent appropriate written notifications when required to tell us about any changes, events or incidents at the service. The registered manager had support from a deputy manager and plans were underway to develop senior staffs' roles in providing further management support. Staff working at the service told us they were motivated and were clear on their own, as well as other people's roles and responsibilities. Improvements were being planned and resources made available to secure the maintenance and development of the service. This included improvements to the building and furnishings. The service was being developed with good leadership.

The registered manager took opportunities to involve people in developments at the service. They told us people were involved in choosing the furnishings for their own rooms and they had chosen the overall colour for the new stair carpet. The registered manager told us they would make the final choice of carpet so that they could apply the principles of good dementia care to the development. For example, they knew to avoid heavily patterned carpets that could be disorientating to people with dementia. Developments were planned with people's involvement and in line with good practice guidelines.

People using the service knew the registered manager well and told us they regularly saw them and that they, "Interacted with all the staff." Families we spoke with were positive about the registered manager, as were other professionals. One social care professional told us the registered manager was, "Approachable," and another professional told us, "The registered manager is very good at reporting any issues," and that they were, "Very honest." Other professionals also told us the registered manager had responded well to feedback when they had suggested changes. Staff told us they could always talk to the registered manager about anything. People experienced the service being managed in an open and approachable way.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 People were not protected against the risks associated with medicines as procedures designed to reduce risks were not followed and sufficient quantities of medicines were not maintained. In addition, people were not protected from unsafe care or treatment as risks to people were not always assessed and reasonably practicable steps taken to mitigate such risks were not evident. Regulation 12 (1) (2) (a) (b) (g) and (f).

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements were not being met and we have taken enforcement action.