Ryefield Court Care Limited

Ryefield Court

Inspection report

Ryefield Avenue
Uxbridge
Middlesex
UB10 9DE

Tel: 01895707106

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This comprehensive inspection was unannounced and took place on the 20 and 22 November 2018. At our last comprehensive inspection on the 14 March 2017 the service was rated outstanding.

Ryefield Court is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. In the case of Ryefield Court, no nursing care is provided. The home can accommodate up to 60 people in one adapted building over three floors which are run as separate units, each of which have separate adapted facilities. The unit on the second floor specialises in providing care to people living with dementia.

The registered manager who was in post at the last inspection had left and at the time of this inspection, there had been a new registered manager in post for two months. '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.'

During the inspection we found some aspects of medicines management were not always carried out safely. The provider introduced plans to address the areas that required improvement when we pointed these out to them.

The provider's arrangements around the control and spread of infection were not always effective. We identified several issues which fell short of good practice.

People did not always receive person centred care that met their needs. A few people were woken up early in the morning when there were no indications that this met their needs, wishes or preferences.

Care plans were not always person centred and detailed, to address how people's needs were to be met. For example, the care plans to support people with their elimination care needs did not make clear how these needs would be met.

The provider's quality assurance systems and governance arrangements were not always effective because they had not identified the shortfalls we identified at this inspection, so they could make the necessary improvements and protect people from the risk of receiving unsafe and inappropriate care. Once we pointed out the shortfalls, the provider started to address these promptly.

Whilst the home provided a warm, clean, well maintained and inviting environment for people, the unit for people with dementia did not always support their orientation and independence because of a lack of signage, the use of colour and features. We have made a recommendation to the provider about this.

The provider had recruitment processes which were not always adhered to robustly. The registered manager stated they would make sure that these were adhered to as required.

The provider had policies and procedures in place to protect people from abuse. Staff we spoke with had received training and knew how to respond to safeguarding concerns.

Staff had up to date training, supervision and annual appraisals to develop the necessary skills to support people using the service.

People's dietary and health needs had been assessed and recorded so any dietary or nutritional needs could be met. People were supported to maintain healthier lives and access healthcare services appropriately.

The provider worked within the principles of the Mental Capacity Act (2005). People were generally supported to have choice and control over their day to day decisions.

Before coming to the service, the provider undertook an assessment to determine if the service could meet the person's needs.

There was a complaints procedure in place and the provider responded to complaints as per their procedure.

People using the service and staff told us the registered manager was available and listened to them.

We found three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to safe care and treatment, person centred care and good governance. You can see what action we told the provider to take at the back of the full version of the report.

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.

The provider did not have effective arrangements to ensure medicines were always managed safely.

The recruitment procedures were not always adhered to which meant there were risks that people not suitable to work at the service, might be employed.

The standard of practice relating to the control and spread of infection fell short of the provider's procedures.

The provider had safeguarding policies and procedures and staff knew how to respond to safeguarding concerns.

Is the service effective?

Requires Improvement

The service was not always effective.

Whilst the home provided a homely, warm and well maintained environment, these did not necessary meet all the needs of people, particularly if they were living with dementia.

The principles of the Mental Capacity Act (2005) were being followed.

Staff were supported to develop professionally through training, supervision and annual appraisals.

People were supported with their dietary requirements and to meet their healthcare needs.

Is the service caring?

Requires Improvement

The service was not always caring.

Waking people up early in the morning without an appropriate reason, did not demonstrate people were being treated with care and compassion.

We observed other instances where staff treated people with

kindness and respect and observed people were given choices.

Feedback from people using the service and their relatives was positive.

Is the service responsive?

Requires Improvement

The service was not always responsive

Care plans were not person centred and did not always detail clearly how people's needs were to be met. Some care practices did not consider people's needs, preferences and their likes and dislikes.

The support plans recorded some information around people's wishes, views and thoughts about end of life care.

There were a variety of activities that people accessed.

The service had a complaints procedure and people knew how to make a complaint if they wished to.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The provider had quality assurance processes, but these were not effective in making sure the service continued to provide an outstanding service. These had not identified the concerns we found at this inspection so they could be addressed.

People using the service and staff felt managers were accessible and said they listened to any concerns.

Ryefield Court

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.

The inspection was prompted in part by information of concerns we received about the service. These related to the standard of care people were receiving in the home. This inspection examined those concerns in relation to the five key questions we asked of providers.

The inspection was unannounced and took place on 20 and 22 November 2018. The inspection was carried out by two inspectors and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. In this case the expert by experience has experience in caring for someone with dementia.

Prior to the inspection we reviewed all the information we received about the service including notifications. These are information about events and incidents that care providers have to notify the CQC by law. We also considered a report that we had received from the local authority after a recent visit that they carried out at the home.

During the inspection we spoke with 20 people using the service, eight relatives, ten staff members, three health care professionals, the registered manager, the deputy manager, the operations manager and the operations director. We viewed the care records of 12 people using the service, the employment files for four care workers which included recruitment records, supervision and appraisals and we looked at training records for all staff members. We also viewed the provider's checks and audits to monitor the quality of the service provided to people.

Requires Improvement

Is the service safe?

Our findings

Whilst the provider had systems in place to manage risks, we found that these were not always effective in identifying risks and where risks were identified, control measures were not always adequate or not followed to manage the risks.

Some people had been identified to be at risk of developing pressure ulcers and had chair cushions for them to sit on, as part of their management plans to reduce the risk of developing pressure ulcers. On the first day of the inspection we observed two people sitting for at least two and half hours in wheel chairs without a seat cushion, from the time they got up until after they had their breakfast. This meant they were not being appropriately protected from the risk of developing pressure ulcers.

Other people had bedrails in place to prevent them from falls. The use of bedrails carries risks, including the risk of entrapment. We did not see that risk assessments were in place to manage the risks associated with the use of bedrails.

We checked the management of medicines on two floors by looking at medicines administration records (MAR) and tracking the medicines for a few people chosen at random. We saw that the management of medicines were not always carried out as safely as possible. For four medicines the quantity in stock did not match the quantity that should have been in stock, accounting for the number that had been received and the number of signatures indicating that the medicines had been administered. This showed that people had not always received their medicines as prescribed.

There was the use of corrective fluid on a person's MAR, instead of using the appropriate process of clearly crossing and rewriting any information. Another person's eye medicine
had passed the 28 days life cycle since the opening of the medicine but was still in use. For two people there was not a clear record of the quantity of the medicines that had been received in the home to provide a clear audit trail.

The provider had an infection control policy in place to help protect people from the risk of infection and staff had attended training on infection control. An infection control audit was last completed in September 2018. The provider also ensured there was enough personal protective equipment such as gloves and aprons for staff to use to care for people. On the day of our inspection we observed staff not wearing aprons when providing personal care to a person. One of the care workers said they did not normally wear aprons unless they cared for people who were 'bedbound'.

We also saw that one staff member did not have a washing bowl to wash a person and used an inappropriate receptacle to hold soapy water. We checked at least four other bedrooms, including one for a person who had been identified as needing a bed bath and we saw no washing bowls. On the second day of our inspection, new washing bowls had been provided for all people living in the home.

We asked a member of staff how they would clean spillages, for example of bodily fluids, which could pose

risks regarding the spread of infection and if they had a procedure to guide them during that process and they were unable to tell us. There was no guidance for staff, so all staff would be clear and consistent about how to clean spillages. There was an infection control audit, but this has not been very effective in identifying the issues we found as described above.

The above shows that the provider was in breach of Regulation 12 of the Health and social care Act 2008 (Regulated Activity) Regulations 2014.

People using the service told us they felt safe living in the home. Comments included, "Yes, it's very safe here" and "Very good, very safe." The provider had systems in place to help safeguard people from abuse including safeguarding polices and procedures. Staff we spoke with had attended safeguarding adults training, were able to identify the types of abuse and knew how to respond. Responses included, "If I had a concern I would first approach my line manager and discuss with her and then go higher, [including] CQC and the police" and "I report it to the senior manager. Report to safeguarding team."

The provider notified the Care Quality Commission (CQC) and the local authority of any safeguarding concerns involving people using the service and kept a log any safeguarding alerts to provide an overview. We saw evidence that safeguarding concerns were investigated. We discussed evidencing learning outcomes arising from the investigations with the registered manager and on the second day of the inspection they had updated their safeguarding forms to include learning outcomes.

The provider recorded incidents and accidents. The registered manager said they would also address learning outcomes on the incident and accident forms so there was a clear written overview of incidents, patterns and what steps they would take to improve service delivery.

The provider had a health and safety policy dated January 2018 and checks in place to ensure the environment was safe. These included a home environmental risk assessment, fire risk assessments and general risk assessments. Maintenance checks were up to date, such as for hoists, fire equipment and gas safety. The health and safety committee last met in August 2018 to discuss fire safety and risk assessments. Each person had a personal emergency evacuation plan (PEEP). The kitchen was clean and appropriately organised and had a 'very good' food and hygiene rating from the local authority in April 2018. Each floor had a cleaning check list that detailed what needed to be done before, during and after shift and each room was checked daily and signed off.

There was a recruitment process in place that was in the main safely implemented. All four applicants whose records we looked at, had a range of checks before they were offered employment at the home. These included a fully completed application form, employment references, criminal records checks, proof of identity and eligibility to work in the UK. One applicant however did not have a full employment history and another did not have a reference from their last employer or from any previous employers. We discussed these issues with the registered manager and they said they would address these issues promptly.

People using the service and relatives had mixed views about whether or not there were sufficient numbers of staff deployed with the right skills to meet people's needs. Comments from people included, "There is enough staff and they're helpful", "They are a bit short at night", "I pressed the bell for the toilet, she kept me waiting seven minutes", "After four o'clock staff are still here. Press the bell someone will be here" and "[There is] one staff on the corridor, press the button and they come" Relatives told us, "I think there needs to be more carers in the evening, my [relative] says they have to wait for the call bell at night", "Can be short staffed. It can be daytime or night time" and "There seems to be enough staff."

Care workers said, "Most of the time we're fine unless people call in sick", "We have enough staff, [but it] depends on the team and if they have a lot of new people. They try to keep the same people on the floor", "We have a stable staff team in whole building. The same people work on the same floors so get to know residents better and they look forward to seeing you" and "Of course we have enough staff. If someone is off sick they try to call bank staff." A healthcare professional told us that at times staff are very busy and more staff would be helpful. They have experienced trying to locate their patient themselves rather than staff helping because staff were busy. However, they also noted, "Staff are really friendly and try to be there for you."

During the inspection on the first day, the second floor only had one care worker as the second care worker did not come into work. The senior said she covered the shift, however we saw in the morning the senior was doing the medicines rounds and that left one care worker to attend to people using the service and answer call bells which were continually ringing. The registered manager showed us they used dependency assessments which indicated people's level of needs and this was used to inform how the rotas were completed.

The provider had appropriate arrangements for the storage and disposal of medicines. There were air-conditioned clinical rooms where medicines trolleys were kept and medicines were stored. The temperature of the rooms and the medicines fridges were carefully monitored to ensure medicines were being stored appropriately.

There were procedures around the management, storage and checks on controlled drugs (CDs) were appropriately followed. A random check of some CDs showed the amount tallied with what should be in stock and that these were being stored appropriately. MARs were in good order and signed to show medicines had been administered except in one case. There were medicines protocols where medicines were prescribed to be administered when required so staff were clear when to give those medicines. In two cases these were not in place but staff proceeded to complete these as soon as they were able to.

Where a variable dose of a medicine was prescribed staff recorded the actual quantity of the medicine they administered. Some people were prescribed creams and others topical medicines to be applied. There were body charts in place to show where these medicines were to be applied.

Staff who administered medicines had completed training, workbooks and observations to test their competency and ensure they were administering and managing medicines safely.

Requires Improvement

Is the service effective?

Our findings

During the inspection the management team told us that the environment on the dementia unit was as far as possible tailored to the individual needs of people living on that unit. However, one of the main aims of a dementia friendly environment is to help people find their way around which in turn reduces disorientation, frustration and behaviour that challenges and improves well-being and independence. (Dementia Friendly Environment, Social Care Institute for Excellence). Our tour of the unit for people with dementia showed that there was not much in terms of signage, use of colour and features that could help people find their way around. We discussed this with the registered manager who agreed to review how the dementia care unit could be improved.

We recommend that the provider seek and implement national guidance in relation to providing dementia friendly environment.

People's needs were assessed prior to moving to the home. Most people and relatives we spoke with said they were involved in planning their care. One relative commented, "They did a care plan with [person] and went through all their medical history etc and said this is what we can offer." Prior to admitting new people who had been referred to Ryefield Court, senior staff visited them to carry out a needs assessment to find out if the person's needs could be met by staff in the home and to which unit they should go. The assessment included people's medical and mental health histories, diet, personal care needs, information about the person's sexuality, spiritual needs communication preferences and any special needs. For example, we saw that one person required a sensor mat.

Staff working at Ryefield Court were supported in their roles. New staff spent one week supernumerary when they completed their induction and shadowed more senior staff. The induction included being shown around the home, getting familiar with the people using the service and policies and procedures of the service. After the one week they were allocated a mentor to support them in their role. A new care worker told us, "I could not have asked for a better induction." New care workers were also supported to complete the Care Certificate. The Care Certificate is a nationally recognised set of standards that gives new staff to care an introduction to their roles and responsibilities.

We looked at the provider's training records for the home and noted that all staff received training the provider considered mandatory. For care staff the mandatory training included manual handling training, food hygiene, health and safety and infection control. Staff responsible for managing medicines also received specific medicines training and their competencies to manage medicines were assessed. Staff also undertook training that was specific to the people they were supporting such as dementia, diabetes and behaviour that challenges training. The registered manager was a dementia champion which meant they were able to lead in good practice when supporting people living with the experience of dementia.

Staff were supported to develop professionally through supervisions, appraisals, team meetings and daily handovers. A relative told us, "From what I witness staff have a lot of patience and have the skills to work with people with dementia. I have never seen anything that would raise concern."

People and their relatives were generally happy with the food and told us, "Food can get a bit samey", "[Relative] loves the food. I have lunch with them weekly. They are given a choice and asked what they would like", "Food can vary. It repeats itself. When [person] first came [to the home], a lady did sit with me and asked what kinds of food [person] liked" and "Food and tea and coffee mornings are very good at encouraging people to come and visit."

The chef said staff asked people what they would like to eat each day, but people could ask for meals outside of the main menu. We saw one person had their own menu of choices if they did not like what was on the menu. The chef said they attended residents' meetings where catering was discussed but also got to know the people using the service and their likes and dislikes over time. The chef had a record of people's required diets such as if they were diabetic, had high cholesterol and/or needed soft foods.

When we observed lunch being served we saw people were shown what was on the menu and then served. Food was not pre-plated which meant people could make their choice at the time they were being served. The dining rooms had a pleasant atmosphere with people talking amongst themselves and with staff.

People using the service could invite family or friends to join them for meals and we saw a relative joined a table to have lunch. The home also had a private dining room that enabled people using the service to host up to eleven family or friends at no cost to themselves. This included a silver service waited three course meal with alcoholic and non-alcoholic drinks. There was a bar/bistro area where people could enjoy alcoholic and non-alcoholic drinks and snacks throughout the day and evening. During our inspection, the service was hosting a community coffee morning and we saw a number of people from the community enjoying the home's hospitality. Later in the day, we saw people taking part in a wine tasting activity.

The service had daily handovers so care workers knew what had happened on the previous shift and what was required of them each day. One care workers said, "We have a daily handover. It's a very good team here."

People's healthcare needs were recorded in their care plans with relevant guidance. We saw that the professionals people saw included speech and language therapists, their GPs and district nurses. The outcomes of the visits were clearly recorded as well as the instructions to care staff about how to support people, for example with eating and drinking or to administer new medicines. When required, people's weights were monitored and audited. People told us, "All healthcare professionals come and see me here" and "They take me in the car to hospital appointments." Relatives' comments included, "They normally phone to say if [person] has a GP or hospital appointment and we are given the choice if we want to go with them", "One good thing is they take [person] to medical appointments" and "They always inform us if letters come through for an appointment." A healthcare professional who visited the home regularly told us, staff were able to provide information asked for and staff were around if they needed someone to talk to. As far as they knew, staff followed up on things, for example, if they were requested to make a referral they did. Another healthcare professional said, "They could do with a bit more staff. Most of the time they follow through on requests."

The premises were appropriately maintained and were clean on the day of the inspection. Security was maintained in that access to the home was controlled and only people who had the relevant codes could enter the building. There were lifts which gave access to all the floors. These also had codes so that only people who had the codes could use these. Staff told us they had all the equipment they needed to care for people. Furniture, fittings and fixtures in the home provided a homely feel. People's bedrooms were personalised and many brought personal items such as pictures, photos and personal items of decoration to provide familiarity and comfort.

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.

Staff we spoke with understood the principles of the MCA in terms of people having choices. Comments included, "I ask what they want, if they want a wash or a shower. They always have a choice", "They have capacity until we know they don't" and "If they want to go to bed, or meal time they have a choice what they want and for personal care. They always have a choice." We saw during the course of the inspection that people were asked for their choices for example about their meals and whether they wanted to take part in activities.

We noted that people had not always signed their care records to show they had consented to their care, although people and relatives said they had been involved in developing these. We saw a number of restrictions in place in the home, such as bed rails and the use of sensor matts. Where required, people had mental capacity assessments to determine their capacity to make a decision around their use of bedrails and sensor mats. If they did not have capacity, best interests decisions were made with others regarding these decisions.

We also saw people who were being deprived of their liberty had authorisations in place after appropriate DoLS applications had been made to the local authority.

Requires Improvement

Is the service caring?

Our findings

Most people in the home were treated with respect and compassion. However, some people were being woken up early in the morning without an appropriate reason when some of them were sleepy. This did not demonstrate these people were being treated with care and compassion. We discussed this with the management and they took action to address this on the second day of the inspection.

People using the service told us, "Relatives and staff, they come and sit with us, we all talk" and "The staff are all caring, not rude." Relatives were happy with how staff interacted with people and said, "Excellent care. Communication is good. All [person's] needs are met. They get [person's] sense of humour. Everybody takes time to listen to the residents", "Staff are very nice. They listen to any problems", "Staff have been very accommodating and patient with [person] and "I really love this place. They make you feel at home and they make [person] feel great." A religious leader said, "I think they look after the residents well. I have former parishioners in here who speak well of it. They are happy and settled."

We observed many positive interactions between staff and people who use the service. In the morning staff greeted people and throughout the day staff engaged positively with people. There was not a time when staff did not answer people if they asked something. Staff made sure they took the time to listen to people and to answer them. Staff called people by their preferred names and showed respect to them.

When staff supported people, they explained what they were doing so people knew what was going to happen and were able to make decisions. We saw that staff offered information to people whenever possible so they could make choices by explaining what was on offer. One person said, "I live upstairs, I'm asked if I want to go downstairs to join in." Staff told us, "People normally tell us when they want to go to bed. If they don't want to go, we can't tell them to. It's up to them when they want to go to bed", "Everybody is an individual and we treat them as individuals. We ask them how are they feeling, what they want to wear, any concerns" and "We always ask them. We give them a choice of clothes. We show them the menu. It's their choice and their home. We look after them."

We saw people could sit where they wanted to. Some stayed in their rooms, others sat in the lounges and in the corridors. When people had visitors they could choose to sit in their bedrooms or in the communal areas so they could spend their time with their relatives and friends. We saw refreshments being offered to people and their visitors so they could share these together.

People's privacy and dignity were maintained. People always received care in their bedrooms or in the bathrooms with the door closed. One person said, "They knock on the door and help me get up" and a care worker commented, "When we do personal care we draw the curtains and we knock at the door even when they ring the call bells." Staff respected people's dignity and tried to promote their independence. Comments from staff included, "I am always asking what they would like and encourage them to do things themselves. Always look at it like they do know what they want, like they have the capacity to do it. We promote independence" and "[With personal care] talk to them, ask them what they want, do they want to do something themselves. Just talking and asking how they are. If I am doing something [for them] I ask

what they want. Ask people when they want to get up." A relative told us, "[Person] can stay in bed all day if she wanted. Personal care is very, very good."

Requires Improvement

Is the service responsive?

Our findings

On the first day of the inspection we arrived on the second floor just before 6.30am and saw that there were six people who were up sitting in their chairs. Three of them were sleeping in their chairs in the lounge. The care staff on the floor were at the time getting another person up. Later they helped a second person to get up. That person was sleepy in bed and when staff uncovered them, they pulled the duvet back up to cover themselves again and closed their eyes.

When we asked staff what time they started to get people up in the morning, two staff told us at 4am and a third said at 4:30am. We looked at the people's care records and could not always see any instructions about the time for people to go to bed or to get up. However, in two of the people's care files who were up early on the morning of the inspection, we saw written, '[Person] likes to get up around 7am and likes to have tea and biscuits after receiving personal care.' On the morning of the inspection the person was fully up and dressed by 6:15am. This person and two other people they were sitting with in the lounge, did not get tea, until 7am and there was no television or music on until 8:15am. A second person's file recorded, '[Person] likes to get up at around 9am and likes to have her breakfast in the dining room.' This person was also up and fully dressed by 6:15am. When we discussed this with the staff they said it was because the person was incontinent and when they were washed, they became awake and were helped to get up rather than staying in bed until their usual time.

We could not see any reasons for people to be up that early in the morning, particularly if they were asleep in their chairs or as demonstrated by the person who pulled their duvet back up and who seemed reluctant to get up. Two night care staff said they had been instructed to get a number of people up before the day staff came on duty. When we asked the management staff and a team leader about this practice, they all said they were unaware of these instructions.

One care worker told us when people were wet, instead of putting people back to bed they decided to shower them and take them to the lounge. This however raised a further concern about whether people's elimination care needs were being appropriately met in the night and if incontinence aids were being renewed at the appropriate frequency. We looked at people's care plans and whilst there were care plans addressing their elimination needs they did not make clear when people should be taken to the bathroom or their incontinence aids changed and how often.

Some people in the home were on strong pain medicines to be given as required to manage their pain. Whilst there were individual protocols in place for the medicines, we did not see individualised care plans to address pain management. Nor did we see pain charts to show how people's pain was being assessed and also to review whether the medicines being given were effective in managing people's pain. During the inspection we received feedback that one person's pain was not being managed appropriately and we heard one person saying they had pain.

We saw some people had a section in their care plan called, 'My wishes for the future, end of life and palliative care plan'. This noted the person's capacity and who to contact in the event of them no longer

having capacity. It also noted what the person would like to happen to their body after death, for example, to be buried and if the person became unwell if they would like to be resuscitated. However other people's care plans we viewed did not have completed assessments or care plans in place to address their end of life care needs and their wishes for the future. Furthermore, care staff we spoke with told us they had not received training on end of life care or how to engage people and their relatives to talk about this topic. The training records we saw confirmed this. This meant that should people develop end of life care needs there were risks that these needs might not be met appropriately and according to people's wishes and preferences.

We saw that people's cultural and spiritual needs were not always addressed in detail in their care records so staff were clear on how to meet these needs. One person from an ethnic background did not have much information in their care records about their diverse background and needs. At least one person's care plans on eating and drinking said, "No spiritual, cultural or religious requirements" and failed to acknowledge that all people have a cultural heritage, irrespective of their backgrounds.

The above shows that the provider did not always ensure that people received person centred care that met their needs. This was in breach of Regulation 9 of the Health and social care Act 2008 (Regulated Activity) Regulations 2014.

After the first day of our inspection, we gave feedback to the management of the home. On the second day we found that many of the shortfalls we had identified had been addressed. For example, people were no longer being woken up from 4am in the morning and their care plans were being updated to show what their sleeping patterns were.

Relatives told us they were involved in planning people's care and that their needs were being met. Comments included, "At any point I can ask them to change the care plan", "They always contact me if there is anything" and "They seem to listen to the family point of view." Care plans contained information about people's preferred name, language, marital status, and religion. There was a traffic light system for when care plans needed to be reviewed. This was done regularly through individual forms and specific evaluations to reflect people's changing needs. Reviews were not signed to indicate people agreed with them as they were electronically recorded. However, the registered manager told us at the last residents' meeting they had a discussion about printing out reviews in the future, so people using the service could sign them.

The provider introduced an electronic system to manage all the care records in September 2018. Staff were still getting to grips with the system. All care staff were given hand held devices so they could access information about people and also make contemporaneous records about the care people received. The electronic records were password protected so only accessible to people who needed to see them. The new on line ICare system was only a few months old, but the provider planned to eventually allow families to log into people's care plans if appropriate to have direct access to these.

In some people's files we saw a 'This is me life history' which provided details to people's background and life history. The managers told us each person had a life history, however we did not see this in every person's file. This was attributed to the change over from a paper based system to an electronic system.

All people we saw appeared well cared for with a good standard of personal hygiene and most were appropriately dressed for the weather. Two people in the morning said they felt cold and staff went and got cardigans for them. Staff knew people's needs well and understood their preferences and likes and dislikes. These were recorded in their care plans that staff could access using their hand held devices.

People we spoke with were happy with the activities provided. They told us, "Lots of activities, I like a sing song", "They take us out in the mini-bus. Henley in the summer, Uxbridge shopping and Mama Mia at the pictures" and "Every Wednesday a wish is picked and the staff make it come true." This was a project that let everybody make a wish about where they wanted to go, for example we saw pictures of someone having tea at Kew Gardens, and staff facilitated their wish. We saw people using the cinema room and the bar/bistro. The home had an activity co-ordinator who showed us a varied portfolio of past and planned activities for people using the service. Activities in the home included creative art, exercising and singalong evenings. People using the service had free access to the bar/bistro, meals, refreshments, cinema, phones, massage and spa activities and the physio which were included in the fee with no extra charge to the person or their family. The Operations Director told us, "This is to ensure that barriers to the residents taking part in all of what the home provides are removed and families use Ryefield Court as a destination and in turn spend more time with their loved ones."

We also saw the home was very open to welcoming the local community and during the inspection, people from the community had been invited for a coffee morning, students were reading to people and a school choir came in to sing. We were told, on Christmas day people from the community with no family were invited to dinner at Ryefield. The service also raised money for community events. We saw evidence of a party for breast cancer and a cake sale and raffle for Alzheimer's day where the community were welcomed to join in.

The provider had a complaints procedure and people and relatives we spoke with knew how to make a complaint. We saw complaints were investigated and responded to in line with the procedure. We discussed with the registered manager evidencing learning outcomes on the complaints form and on the second day of inspection the complaints and safeguarding investigation forms were updated to include clear outcomes and the learning that needed to be implemented to prevent reoccurrence.

Comments from people using the service and their relatives included, "No complaint, but I would take it to senior management", "No complaint. Enquires and issues are dealt with, no problem", "Never complained. They keep us informed" and "I feel [person] is in safe hands and if anything happened they would let me know."

Requires Improvement

Is the service well-led?

Our findings

The provider had a range of processes and systems to monitor the quality of services provided in the home so any areas that needed improvement were identified and addressed. These included a number of audits and checks. Our findings during the inspection shows that while the provider took pride in delivering a quality service which had been previously rated outstanding, their quality assurance systems were not very effective because they had not identified the areas of poor practice and the other areas for improvement that we found at this inspection.

For example, whilst there were night checks carried out by the management team, they had not identified what we had found in regard to the number of people who were woken up in the morning, when we could not see a valid reason for them to be up so early. The provider carried out infection control audits but had not identified that there were no washing bowls in people's rooms or that there was no procedure in place to deal with spillages, even though the infection control policy referred to that matter.

The provider also carried out a quarterly medicines audits and a number of related checks, but these had not identified the shortfalls we found in relation to the management of medicines. One eye medicine had passed it's 28 days life cycle but was still in use. In some cases, daily counts of medicines were undertaken but these were not consistently carried out for all medicines. As a result, discrepancies in the quantity of the medicines in stock were not identified so these could be addressed.

The audits around the recruitment of staff had also not been that robust because we identified a few minor shortfalls that the provider had not identified.

The above paragraphs show a breach of Regulation 17 of the Health and social care Act 2008 (Regulated Activity) Regulations 2014.

Audits included health and safety, infection control, medicines, person centred care and fire safety. A representative of the provider completed a monthly overall audit of the service and a sperate quarterly audit. Audits were scored, comments made and action plans completed to improve the care provided. We also saw evidence of unannounced night checks by managers.

The provider had an improvements and enhancements plan for 2018 which included moving to electronic systems and doubling the training budget. The new ICare electronic care planning system had been implemented in September 2018 and we saw evidence that the management team had reflected on what went well and future considerations as a result of the implementation.

People using the service had the opportunity to give feedback and share their views with the provider about the service they received through a number of ways including surveys and residents' meetings. A residents' committee had recently been set up. A committee member told us, "Anyone can come to the sub-committee and points are raised to the committee. We made improvements to the size of battered fish which is now smaller, so we can finish what is on our plate."

We saw staff also had the opportunity to participate in team meetings and share information so they were involved in the way the service was provided. One care worker said about team meetings, "We communicate so we know what's going on and solve problems. It's all about team work and communication."

People using the service and their relatives found the registered manager, who had taken up post two months previously, approachable and told us, "I have confidence in the management. [Registered manager] is very approachable", "Anything you put to [registered manager] she deals with. She's friendly, excellent" and "Everyone has dealt with our queries very nicely." Staff were also positive about the support they received from the registered manager. Comments included, "[Registered manager] is very supportive and easy to talk to", "[Registered manager] is very good with residents. We see her on the floors and she is also there for carers. Deputy is also new and very good. It's a good team. I feel very safe. I can go to them and they deal with it" and "We have a fantastic manager. You can discuss anything."

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 9 HSCA RA Regulations 2014 Person-centred care The provider had not always ensured that the care planned and provided to service users was appropriate, met their needs and reflected their preferences. Regulation 9(1)(a)(b)(c)

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 ensured that all risks to the health and safety of service users of receiving care and treatment were appropriately assessed. They had also not done all that was reasonably practicable to mitigate such risks. They had not ensured that medicines were always managed safety and that the infection control procedures were robustly adhered to. Regulation12(1)(a)(b)(d)(g)(h)

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 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)(2)(a)(b)