Rylands Care Limited

The Rylands Nursing and Residential Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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?	Requires Improvement

Summary of findings

Overall summary

The Rylands Nursing and Residential Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. It is registered to support up to 44 people. At the time of our inspection there were 38 people using the service.

At the last inspection in September 2016, the service was rated Good. At this inspection we found that the service was rated Requires Improvement overall. The key questions of 'is the service safe?' and 'is the service well-led?' were rated as Requires Improvement. Other key questions were rated as Good.

Sometimes there were not always enough staff. The registered manager was attempting to get more staff.

There was sometimes insufficient guidance about 'as and when required' medicines which meant people may not always receive their medicine at the right time.

We saw risks were assessed and planned for to keep people safe, but occasionally some plans were not always updated when people's needs had changed.

Systems in place had not always identified some concerns.

People were protected from avoidable harm by suitably recruited staff who understood their responsibilities and could recognise the potential signs of abuse.

Infection control measures were in place and the building was being appropriately maintained and checked on to keep people safe.

People were supported by appropriately trained staff who were supported by the management team. We have recommended staff continue to receive updated training so all necessary training is up to date. People had access to suitable food and drinks and were given a choice. People also had access to other health professionals to help them remain healthy.

People were treated with dignity and respect, could make decisions about their support and were encouraged to remain independent where possible.

Staff knew people well and people had plans in place which included details of they liked to be supported. Activities were available for people to partake in, both on an organised group manner and also individually. There was a system in place to record and monitor complaints. The service had considered people's end of life needs.

It was felt the registered manager was approachable and they were supported by the provider. People and

staff were encouraged to offer feedback.

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.

People did not always have support from appropriately deployed staff.

There was not always sufficient information regarding medicines.

People had risks to their safety assessed and planned for but some plans were not always updated.

Lessons had been learned when things had gone wrong.

Staff understood their responsibilities about safeguarding and protecting people from abuse.

Infection control was in place and the home was clean and free of malodours. The building was appropriately maintained.

Is the service effective?

Good

Staff were working within the principles of the Mental Capacity Act.

The service assessed whether they would be able to support people prior to them joining the service.

Staff had sufficient training to support people however we recommend staff continue to receive updated training so all necessary training is up to date.

People were supported to have a choice of food and drinks appropriate for their needs.

People had access to other health professionals to keep them healthy.

Is the service caring?

Good

The service was caring.

People were treated with dignity and respect.

People were supported to make decisions about their care and to be independent where possible.

Is the service responsive?

Good

The service was responsive.

Staff knew people's needs and people had relevant plans in place.

People were supported to partake in activities.

Complaints were dealt with appropriately and a policy was in place.

The service had considered people's end of life needs.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Systems were in place however they did not always identify issues.

People were asked for their opinion about their care.

Staff felt supported and there was positive feedback about the registered manager.

The Rylands Nursing and Residential Home

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 was 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 we had received from the local authority safeguarding adult's team. It was also prompted in part by notification of an incident involving a person using the service passing away. This incident is subject to an investigation by the local authority and as a result this inspection did not examine the circumstances of the incident. This incident prompted us to bring our planned inspection forward to look at current care delivery and the provider's response to the local authority's concerns.

This unannounced inspection took place on 6 April 2018. The inspection team consisted one inspector and a Specialist Advisor with a nursing background.

As part of the inspection, we reviewed the information we held about the service, including statutory notifications. Statutory notifications include information about important events which the provider is required to send us by law. We reviewed feedback from the commissioners of people's care to find out their views on the quality of the service. We reviewed information shared by the Local Authority Safeguarding Team. We used this information to help us plan our inspection.

During the inspection, we spoke with three people who lived at the service. We also spoke with a visiting health professional. We spoke with the registered manager, the clinical lead, nursing staff, four members of staff a member of staff form the kitchen. We carried out observations throughout the service to help us understand the experiences of people living at the home and to review the quality of care people received. We looked at the care records for seven people. We also looked at other records relating to the management

of the service including staff files, training records, complaint logs, accident reports, audit records, and medicine administration records and other quality assurance systems.

Requires Improvement

Is the service safe?

Our findings

People and staff told us there were not always enough staff. One person said, "Sometimes I ring the bell [call button in people's rooms] and I might have to wait in the morning, but it is nothing I can complain about." One member of staff said, "It seemed ok. We've been struggling in the last week though as we've had new residents and people's needs have changed. I don't think the staffing levels are appropriate. We can't always answer buzzers." Another member of staff said, "Mornings are a struggle. We have more people and needs have changed. We only have a few people who only need one member of staff to support them, the rest need two staff at a time." The building layout also meant that staff could be spread out over the home; one member of staff we spoke with acknowledged this as a challenge. We observed multiple occasions when the communal areas had no staff present to be able to respond to people's needs, despite this being identified as a need in the home's action plan. We saw some people who were at risk of falls had pressure mats to sit on, so that if they stood up it would alert staff to be able to attend. When we spoke to the registered manager they explained that a number of staff had recently left and that those they had recruited to replace them had not stayed. The registered manager said, "Our staff are very good at covering where possible." They went on to explain they were still trying to recruit and they were sometimes using agency staff to assist in the home. This meant improvements were required to ensure sufficient staff were deployed effectively to ensure they would meet any changing needs in people they support.

We looked at how medicines were managed. Some medicines that had been prescribed on a 'when required' basis did not have any written information to support staff on when and how these medicines should be administered. Where information was available to the staff in the form of a protocol, we found the information was not always detailed enough to ensure that the medicines were given in a timely and consistent way by the staff. This meant there was a risk that people may not receive their 'as and when required' medicine when they needed it as staff did not have guidance to follow. For example, one person was prescribed a medicine to help calm them when they became agitated, however the guidance in relation to this was not robust. This meant the person may have been at risk of being given the medicine when they were not agitated and they did not require it, as the guidance was not clear. When we fed this back to the nursing staff and to the registered manager, action was taken and more detailed protocols were put in place. Following the inspection evidence was shared with us that extra PRN medicine guidance was put in place for all people who had PRN medicines. We checked stock levels compared with records to ensure they matched for 'controlled drugs'. Controlled drugs are medicines that require additional monitoring due to being subject to additional legislation. All stock levels matched and were stored appropriately. We saw temperature checks were taking place on rooms and refrigerators where medicines were being stored and action had been taken when the temperature was outside of the specified safe range. This meant further improvements were required to ensure staff had the appropriate guidance to administer medicines safely.

Risks to people's health, safety and wellbeing were being assessed and plans were put in place to mitigate the risks to peoples' safety. However, we saw some examples when plans had not been updated following a change. For example, one person had a wound and there was a wound plan in place. The wound plan was not clear and the support the nursing staff told us the person required did not match the plan. Body maps were not being used effectively to monitor the wound as it did not include details such as size and condition.

Following the inspection we saw evidence that photographs had been taken of the wound but there were no measurements included and no updated photographs had been taken. Therefore, due to there being no updated body maps or updated photographs it was not possible to ascertain whether the wound had healed, stayed the same or worsened. This posed a risk as the person may not receive consistent care if their plan was not up to date and the wound was not always being effectively monitored. This is a particular risk as the service would utilise agency members of staff and they may not have sufficient information to support the person effectively. However, we also saw examples of plans being up to date. In another example, some people needed support to move and we saw this had been assessed and plans in place to guide staff how to assist people such as number of staff, equipment required and how to use the specific equipment. If people had bed rails attached to their beds, then regular reviews had been taking place to ensure they were still safe and appropriate. This is important as people can easily injure themselves on bed rails if they are not fitted correctly or the needs of the person has changed, so regular review is necessary. Some people had experienced falls and action had been taken try to reduce the likelihood of another fall occurring. For example, one person had fallen and an alarm mat had been introduced to alert staff to when the person was standing from a chair. The person's GP had also been contacted to investigate the potential reasons for the fall. This meant that the home needed to ensure plans were consistently updated for all people to avoid people potentially receiving inconsistent care.

The provider was learning lessons from things going wrong. For example, observation charts (for blood pressure and temperature readings) had previously not been fully completed but we saw examples that were up to date. Equipment, previously thought to be unavailable was now available. This meant action was taken when it was identified that there were omissions.

People were protected from avoidable harm by staff who understood their responsibilities to keep people safe. Staff could describe different types of abuse, the signs to look out for and what they would do if they suspected someone was being abused. We saw appropriate referrals had been made to the local safeguarding authority and there was a safeguarding policy in place. That meant staff and systems helped protect people from avoidable harm.

The service followed safe recruitment practices. Staff files we viewed included application forms, records of interview and appropriate references. Records showed that checks had been made with the Disclosure and Barring Service (DBS) (criminal records check) to make sure people were suitable to work with people who used the service. DBS checks are made against the police national computer to see if there are any convictions, cautions, warnings or reprimands listed for the applicant.

Infection control measures were in place to ensure people were protected. Infection control audits were being carried out in order to check the home was following guidance and there was an appropriate policy in place. The home was free from any malodours and we saw there were cleaning checks in place to ensure equipment and rooms were cleaned appropriately.

The building was maintained appropriately as checks were being completed in line with guidance to help keep people safe. This included water hygiene and temperature checks and electrical and gas checks. The fire equipment was also checked and the home had fire drills to ensure staff had practice in the event of a real emergency occurring. People had 'Personal Emergency Evacuation Plans' (PEEPs) in place so staff and emergency services had immediate information about how people needed to be supported to leave the building.

Good

Is the service effective?

Our findings

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. We saw staff explaining the support they were offering to people and they would check with people first prior to supporting them. For instance, we saw staff checking with people whether they wanted any sauce with their food rather than just pouring sauce onto their plates. When people were being hoisted or assisted to stand, staff would interact with people to ensure they knew what was happening. Staff we spoke with were able to tell us what 'capacity' meant and how they supported people to make choices. One member of staff said, "You always give people choices and options." This meant staff were working within the principles of the MCA.

People can only be deprived of their liberty so that they can 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 saw that appropriate decision-specific mental capacity assessments were being carried out and plans were put in place in people's best interests when they lacked capacity. These had also been reviewed regularly. One person who was being given their medicines covertly had a best interest assessment recorded regarding their covert medicines which was discussed with other professionals and included the relevant details of which medicines this included.

People's needs were assessed prior to them moving into the home so the service was checking that they were able to meet people's needs. One the day of our inspection a person was moving into the home and we saw a pre-admission assessment had taken place. Relatives also told us they felt supported by the staff through the period of time their relative was moving in. We saw 'hospital passports' had been written for people, which was a summary document which recorded people's main health conditions and support needs they have to enable a more effective transition between the home and hospital or other health services.

Staff told us and we saw evidence of staff completing training. Staff told us they had a mixture of face to face training and online training and that it was clear and useful to them. A visiting health professional said, "I rate the staff here –they're good." A training matrix was also in place which was tracking the training each member of staff. This did note some gaps in some training for some staff; however when we spoke to the registered manager about this they explained they were in the process of implementing training courses which would be held more frequently why it appeared that some staff did not have up to date training. When we spoke with staff, they were able to answer questions in relation to safeguarding and the MCA. We recommend staff continue to receive updated training so all necessary training is up to date.

People had access to other health professionals. We spoke with a visiting health professional and they said they were "not concerned" and that referrals into their service were appropriate. The health professional also told us they felt the record keeping was good. We saw records which showed people had access to

doctors, Speech and Language Therapists (SaLT) and podiatrists. For example one person had lost weight and we saw a referral had been made to their GP. This meant the service was working across organisations to deliver effective care and support and helped people to access healthcare services.

People told us they liked the food, they told us they had choices and we saw alternatives being offered. One person said, "It's [the food] lovely." Another person said, "Everything is very nice with the food." We heard one person comment, "It's [the food] not enough – I want some more." Staff then offered this person more food. We observed staff asking people what they would like for lunch and people were having food and drinks appropriate for their needs, such as thickened fluids or pureed food. Some people had a particular support need, such as having a percutaneous endoscopic gastrostomy (PEG) fitted. A PEG is a tube which passes into the stomach which helps people to maintain their nutritional intake if they can no longer swallow. We saw there were detailed plans in place to support staff in effectively caring for people with a PEG. This meant people were supported to maintain a nutritional intake and had choices.

The home has two main floors and a mezzanine level, with bedrooms on all three levels of the building. Lifts were available to enable people to access all levels of the building. There were two main lounge areas and an adjoining conservatory which people could choose to spend time in. We saw there were specially adapted bathrooms with equipment available so people could use them where possible. Some people had display boxes outside of their bedrooms with some personal effects in such as photographs or ornaments; however this facility was not available on everyone's bedroom. Some areas of the home were going through improvements such as new flooring and soft furnishing. The registered manager explained this was an on-going programme of environmental improvements. They also told us they were planning on changing some of the crockery so it was not just plain white. By having non-white crockery it can assist people living with dementia in being able to differentiate between food and other items around them. Everyone's bedroom had their name displayed to help people find their rooms. Other rooms, such as bathrooms were also labelled to help people identify them.

Good

Is the service caring?

Our findings

People told us the staff were nice and they were happy in the home. One person said, "They are looking after us very well thanks." Another person said, "I am happy they try their best." Another person said, "The are very good, they work extremely hard." Another person commented, "I think it is very good, I am quite happy." A visiting health professional we spoke with told us, "The staff are really nice to people. I don't think they could do a lot more."

People were treated with dignity and respect. We heard staff using appropriate language, for example they used the term 'clothes protector' rather than the word 'bib' when offering people these at lunchtime. We observed that when people were being hoisted that staff explained things to people and told them what would be happening next. Staff were also careful to ensure people remained covered during hoisting so the person's under garments wouldn't be on show. All staff we spoke with were able to give examples of helping people maintain their dignity, such as keeping them covered and shutting doors during personal care.

We saw that people were supported to make decisions about their care. One person said, "There are no strict rules. I have a choice." We saw people were offered choices about their food and where they would like to spend their time. Visitors were able to visit at a time convenient for them. One person said, "The home is near to where my relative lives. They can pop in." That meant visitors were supported and able to visit the home at a time of their choice.

People were supported to be independent. We saw people had their mobility equipment, such as walking frames, close by so those who were able to use them could walk around when they chose to. We observed a member of staff encourage a person to try and eat independently which they then did. This meant people were encouraged to try and maintain their independence where possible.

Good

Is the service responsive?

Our findings

People told us they felt appropriately cared for. One person said, "They [staff] look after me very well." We saw staff supporting people in line with their needs. Staff we spoke with knew people well and were able to tell us about people's needs, their life histories and their preferences. For example, one member of staff we spoke to told us about a particular person, "They are cheeky and like banter but they are never rude." Another member of staff told us the same thing about the same person. Staff also told us about another person, "I like listening to what [person's name] as done in their life. This also distracts them [when they became agitated]." Staff were also able to tell us if people had specific needs or health conditions, such as diabetes, or what level of support people needed. Care plans were regularly reviewed and we saw changes had been made following reviews. This meant people were being supported by staff who got to know them.

People were supported to partake in activities and there was an activities coordinator and other staff which supported this. However, the activities coordinator was sometimes expected to support with care rather than delivering activities. One person said, "I am quite happy. I read a lot and watch TV but I prefer reading." They went on to say, "They helped me make an Easter basket." Another person said, "We have a notice of what is on the next week." A member of staff told us, "Some people went out to the greenhouse this week." We saw an activities newsletter which made people aware of what was available to partake in the following month. There were both group organised activities available and things people could do individually should they choose to. We observed people carrying on with their own hobbies, such as colouring, when they were able to do so. There were also items within the home that people had decorated and made and there was space outside where people could partake in outdoor activities, such as gardening.

We saw the service had considered and spoken to some people about their preferences about the support they would like to receive near the end of their life. We saw plans in place called 'Future Wishes' which recorded people's choices for their end of life support. It also recorded whether someone had a Do Not Attempt Resuscitation (DNAR) form in place.

We saw a complaints policy was easily available in communal areas for people and relatives to be able to access it. This was also available in large print. No formal complaints had been received recently however we did see evidence of a complaint which had been responded to appropriately. There were multiple compliment cards providing feedback from relatives about the care their loved ones received.

Requires Improvement

Is the service well-led?

Our findings

Systems were in place to monitor the quality of the service and we saw action had been taken when concerns had been identified in some areas but this was not consistent. There were not always enough staff, this had been identified through a dependency tool, the registered manager was aware of this and action was being taken to try to resolve this, however staff told us they felt there was not always enough staff and the dependency tool did not take into account the layout of the building. We asked the local authority for feedback and they told us they have had concerns about, "A resident had fallen due to staff not responding in time to the call bell" near the end of 2017 and yet there were still insufficient staffing levels at times. We saw audits of care plans were taking place which identified areas for improvement. For example, one person's audit had identified that their moving and handling assessment needed to be completed and a particular medicine needed to be added onto their plan. We saw that these improvements had been made. There had been some learning from a recent incident which had occurred at the service and whilst many actions had been implemented, not all action had been completed or was not fully embedded. Other audits, such as the medicines audits had not identified that there was not always enough information for staff when administering 'as and when required' medicines. This meant we could not be assured that systems currently in place were effectively at identifying and resolved all concerns in a timely manner in order to protect people.

The registered manager was being supported by a provider who would also carry out audits. The registered manager told us, "The audits [by the provider] are useful. They are very good and very thorough; they know what they are doing." They went on to say, "The provider shares best practice from other homes." Other audits had also been taking place. The registered manager looked at accidents, like falls, and incidents, such as where and when they occurred and why they had occurred to identify trends. Action plans were put in place and taken was then taken for people to reduce their likelihood of falling. There was also analysis of other trends, such as the number of complaints, safeguarding incidents and how many people had particular health conditions, like pressure sores or infections, in order to monitor the service as a whole. If incidents had occurred swift action had been taken to reduce the likelihood of them reoccurring. For example, an incident had occurred whereby some equipment had not been readily available for staff. We saw that multiple pieces of this equipment were now available in the room where medicines were kept. In another example, a fall kitchen fire had occurred. An action plan had been put in place, staff had been supported to re-train and the fire service was contacted for advice. Action plans were also in place and we could improvements were on-going to ensure the home was continuously improving. This meant the service had taken action to help keep people safe.

People, relatives and staff were encouraged to provide feedback. One member of staff said, "We can give ideas to the manager." We saw surveys had been sent to service users, relatives and staff. Overall positive feedback was received from people and relatives. Where staff had made comments, we were told that meetings had been held to discuss the feedback. There was a whistleblowing policy in place to enable staff to report concerns if they had any. Meeting had also been taking place for people, staff and management. A regular meeting was held between all departments in the home, like care staff, nursing staff, administrative staff, maintenance and management to discuss the home as a whole.

Staff and other stakeholders told us they felt positively about the registered manager and the home. One member of staff said, "The management deserve medals, they have so much to cope with and they are definitely approachable." Another member of staff told us, "The manager is brilliant. They are very approachable. The staff are good and there's a nice atmosphere" and they went on to say, "I love working here, the nurses are great, the manager and clinical lead are great – they listen." The local authority told us they had, "Positive relationships with management." A visiting health professional told us, "I can speak with the manager" and went on to say, "I'd have my parents in this home." The home had been submitting notifications to the CQC about significant events as they were required to do and the home's last CQC rating was being clearly displayed in a communal area.