Ranc Care Homes Limited

Romford Care Centre

Inspection report

107 Neave Crescent
Harold Hill
Romford
Essex
RM3 8HW

Tel: 01708379022
Website: www.ranccare.co.uk

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This unannounced inspection took place on 10 August 2016. At our last inspection on 22, 23 and 30 June 2015 we found the provider did not appropriately assess the risk of, and prevent, detect, and control the spread of, infections. During this inspection we found that the provider had made improvements and the now met the required standards.

Romford Care Centre is a large, purpose-built care home providing accommodation, personal care and nursing care for up to 114 people. At the time of our inspection there were 62 older people, many of whom have dementia, using the service. Each person who lives at Romford Care Centre has their own room with ensuite bathroom, and the service premises are suitable for people with mobility needs. The service is divided into five units, however only three were in use at the time of our visit due to the number of people living in the service.

Following the resignation of the last manager, the service did not have a registered manager in place. However, the provider had employed an acting manager who was running the service. 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.

We found that Romford Care Centre had a team of new managers who were willing to listen to people, people's relatives and staff to make improvements to the service. People, their relatives and staff spoke positively about the management of the service and told us the acting manager was approachable. They told us they were happy with the service and they knew how to make a complaint if they had a concern with it.

People's care and health plans were detailed, person centred and described the individual care, treatment and support people needed and preferred. People or their representatives were involved in the review of care plans and risk assessments and it was evident that care was delivered in line with the principles of the Mental Capacity Act 2005 (MCA).

We found that new staff were appropriately checked to ensure they were suitable to work with people. People told us and records and observation showed that there were enough staff at the service who were kind, caring and friendly with people and relatives. We noted staff ensured people's privacy and treated them with respect and dignity when delivering care. Staff were trained and supported and these gave them opportunity to develop skills and experience necessary to support people. However, we recommended that the provider ensures that all staff have regular formal supervision, annual appraisal, training including attending refresher courses in MCA.

Medicines were stored and administered safely and there was evidence that people had access to

healthcare professionals. People's dietary needs were met through proper monitoring and provision of meals that reflected their preferences.

The premises were clean, bright and spacious with appropriate facilities and equipment available for people's use.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe. People were safe and protected from harm. Staff knew what action to take if they suspected abuse was taking place.

Risks to people had been identified and risk assessments were reviewed. The home was bright and clean, and there was suitable equipment for people to use.

There were sufficient numbers of staff to ensure that people had their needs met promptly and safely. The service followed safe recruitment practices when employing new staff.

People's medicines were managed safely and appropriate arrangements were in place for safe storage and administering of medicines.

Is the service effective?

Requires Improvement

The service was not effective. Some staff did not have training in Mental Capacity Act 2005 whilst others had not had regular supervision and annual appraisals. Although most of the staff were trained and supported, the service did not have an effective system in place to ensure all staff had training, supervision and appraisals.

People were supported to access health services and were provided with nutrition and hydration that reflected their needs.

Is the service caring?

Good

The service was caring. People and relatives told us staff were caring, kind and friendly. They told us staff ensured people's privacy and treated them with respect and dignity.

We noted staff knew people's needs, preferences, likes and dislikes.

People and their relatives told us they felt staff listened to them and they had good relationships with them.

Is the service responsive?

Good

The service was responsive. Staff supported people to engage in a range of activities within the service.

People and their relatives told us they felt staff listened to them and they had good relationships with them.

Is the service well-led?

Good

The service was safe. People were safe and protected from harm. Staff knew what action to take if they suspected abuse was taking place.

Risks to people had been identified and risk assessments were reviewed. The home was bright and clean, and there was suitable equipment for people to use.

There were sufficient numbers of staff to ensure that people had their needs met promptly and safely. The service followed safe recruitment practices when employing new staff.

People's medicines were managed safely and appropriate arrangements were in place for safe storage and administering of medicines.

Romford Care Centre

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 unannounced inspection took place on 10 August 2016.The inspection was conducted by three inspectors, an expert by experience and a pharmacist inspector. 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 received information from a local authority commissioner about the service. We also reviewed all of the information we held, including feedback from people who use the service and their relatives, and notifications of events affecting the service that the provider must send us.

During our visit we spoke with 26 people who used the service and five relatives. Some people who used the service could not tell us about their experiences due to dementia, so we observed their care using the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We also observed care and support being provided in communal areas and in people's bedrooms with their permission.

We spoke with 12 care staff, a maintenance person and the acting manager. We looked at 10 people's personal care and support records, 13 staff personnel records and reviewed documents such as the provider's policies, audits, staff training and supervision records and the minutes of various meetings. We had a guided tour of the premises.

Good

Is the service safe?

Our findings

People and their relatives told us they felt safe living at Romford Care Centre. One person told us, "I am safer here than where I used to be. I feel safe here." Another person said, "When I press the buzzer they come quickly to assist me. They are nice." A relative told us, "[My relative] is safe here because there is always people around." Another relative said, "[My relative] very rarely presses the buzzer, but when [they do] someone responds. I have no problem with [their] safety".

At our last inspection in June 2015, we found that the service was in breach of regulations relating to Safe care and treatment, because they did not appropriately assess the risk of, and prevent, detect, and control the spread of, infections. Following this, the provider sent us the action they were taking to make improvements to the service. During this inspection, we saw that the risks had been appropriately assessed and actions put in place to minimise the risk of infections.

People and relatives told us the premises were clean. One person said, "They clean the rooms, I like it." A relative told us, "I am really happy with the home, it is always clean." We saw that all parts of the home were clean and free from unpleasant odours. Staff wore personal protective equipment such as gloves and aprons when required and they told us that they had attended training in infection control. We noted staff understood and followed their roles and responsibilities for maintaining high standards of cleanliness and hygiene. Records showed that regular infection control check lists were completed and action plans developed and put in place to address any issues. We noted there were three infection control leads with the responsibility of monitoring, identifying and managing infection control issues within the service.

The service had adult safeguarding policies which they followed to report incidents and accidents to appropriate authorities including CQC. Staff told us and records confirmed that staff had attended training in adult safeguarding. Staff we spoke with gave good description of the action they would take to report any incidents of abuse they might come across. They told us they would report incidents to the manager or, if they felt appropriate action was not taken, would raise the issues with the local authority, police and the CQC. During the inspection we noticed how staff effectively dealt with a safeguarding incident between two people. We saw that staff were confident in managing the incident and reporting it to all relevant authorities and relevant relatives. This showed that people were supported by staff who had the skill and knowledge of managing safeguarding issues.

People and staff told us that there were enough staff at the service. They told us staff were there when people needed them. Staff told us that generally the staffing level was sufficient. A member of staff said, "We have a staff rota and I am happy with my hours and shifts. It works well." However, another member of staff told us, "The staffing level is enough, but sometimes when the carers ring to say they are going off sick we can struggle." The member of staff said that the acting manager made sure replacement staff were found to cover staff who were off sick and that there were always enough staff to care for people. The acting manager told and showed us that dependency level was used to decide how many staff were allocated to provide care. We noted that some people were allocated one-to-one staff due to their assessed needs and some had a plan to be supported by two staff to one when, for example, moving or transferring.

There was a good staff recruitment procedure in place to ensure staff recruited to support people were appropriately checked and were suitable. Staff files showed that each staff member had completed an application form detailing their employment history, and contained two written references, an enhanced criminal record check and proof of the staff member's identity and right to work in the United Kingdom.

Each person had a risk assessment which was reviewed monthly. The risk assessments identified possible risks to people and the action staff needed to take to reduce a risk of harm to people. Staff told us they had read the risk assessments and knew what to do in order to make sure that the risks to people were minimal. We noted that the premises were spacious and bright for people to move safely and that there was equipment such as wheelchairs and passenger lifts.

We noted that health and safety checks were regularly carried out. These included regularly checking of fire equipment, annual testing of electrical wiring and gas boilers. Records and certificates confirmed that these had been carried out. Records showed that each person had a personal evacuation plan which detailed their needs should they be required to evacuate the premises. There was an emergency contingency plan which comprehensively outlined actions for named people to take in an emergency that would interrupt care being delivered.

Staff stored medicines, including controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) securely and in a suitable cabinet, and monitored them appropriately. We noted medicines were administered by registered nurses who had relevant training and experience in medicine administration.

We looked at medicine administration record (MAR) charts for 17 out of 62 people and found that staff kept clear records of medicines administration. The records included a photograph of the person and allergy details. We also noted that the records were updated when prescriptions were changed, for example, following a GP visit or a stay in hospital. This showed that staff had up to date information to administer medicine.

There was guidance for staff on when to administer medicines intended to be given when needed, for example for pain or anxiety. However, we saw that one person was prescribed a pain relieving skin patch, and there was no record of the site of application. The nursing staff told us that they used a different site each time to avoid skin irritation, but with no records we could not be sure that they were applied in accordance with the manufacturer's instructions. We discussed this with the acting manager who advised that this would be looked into guidance provided.

Requires Improvement

Is the service effective?

Our findings

People and relatives told us staff had the knowledge and skills they needed to carry out their roles and responsibilities to provide effective care to people. One person said, "The home is lovely. All of the staff are very good. [A member of staff] is lovely." A relative told us, "I am happy with everything. They [staff] do the right thing for people. The staff are nice and know how to care for people." We noted that staff made changes to people's care and support after consultation with health and social care specialists. For example, staff and the acting manager described how they consulted an occupational therapist and provided suitable equipment for one person. This showed that staff knew how to provide effective care by using their knowledge and by working with other professionals. Although people commented positively on the staff, we found staff were not always supported through regular supervisions and appraisals.

Staff told us they had supervision and support by management. One member of staff told us, "Supervision is normally every two months and it is good for me. I find it useful as we can discuss concerns and things. I get to see the notes." Another member of staff said, "I get supervision from the manager. We discuss work and my training needs. I feel supported." A third member of staff told us, "We had a whole home meeting [group supervision] in July. I have not had an appraisal for a while."
However, although most of the staff we spoke with felt supported by the management of the service, we found that some staff had not had the opportunity to be supported through regular supervision and appraisal. Staff files showed that regular (two monthly supervision sessions which some staff told us about) and annual appraisals were not always taking place for some staff. For example, we noted that one member of staff had only one supervision recorded since June 2015 and that supervision did not take place as stated by staff and the acting manager every two months for some staff. The acting manager told us that there were 77 staff employed at the service and not all of them had regular supervision. The acting manager informed us that they were "working on this" and were "establishing regular supervisions and appraisals for all staff". The acting manager said, "I have been managing on my own since November [but now I have deputy manager]."

We looked at staff files and the service's training matrix and noted that most of the staff had attended a range of training programmes including Mental Capacity Act 2005 (MCA) and refresher courses. However, we noted that a few of the staff had yet to complete refresher training in MCA. 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. 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 training matrix showed and the acting manager confirmed that refresher MCA training was planned for those staff who had not yet completed it. A member of staff who had yet to attend their refresher training programme in MCA told us that they had been given a date to attend the training.

Although we found that regular supervision and annual appraisals were not taking place for some staff, we noted that staff were competent in carrying out their responsibilities. However, we recommend that the provider ensures that each member of staff employed has a regular formal supervision, annual appraisal, and refresher attends mandatory training including refresher courses.

Staff told us they had induction when they began to work at the service. They told us they attended detailed induction and shadowing programmes. A member of staff said, "I shadowed when I started for practice and to get used to a routine." Staff told us they had attended annual training in different areas related to their roles. A member of staff told us, "I have had training in dementia, tissue viability, safeguarding, manual handling, fire safety, whistleblowing and first aid. We get a lot of e learning."

Staff respected people rights to make their own decisions about their care and treatment. We noted people and their relatives signed consent forms and care plans stating they agreed to the plans. Staff told us and we observed that people were given choices of how they wanted staff to support them. We saw staff asked and waited for people to make a decision of, for example, being in the lounge or in their room. Staff considered people's capacity to take particular decisions and knew the procedures to follow to ensure decisions were made in people's best interests. This showed staff understood and respected people's rights to make their own decisions.

People and relatives told us the service provided meals that reflected people's needs. One person said, "The food is nice. I like it." Another person told us, "The food is good. But I have no appetite. [Staff] do encourage me to eat all the time." A relative said, "The food is nice. [My relative] gets enough to eat and drink and has a cool box in [their] room. I have even eaten here on a Sunday and the roast is really good". We noted that there was a choice of two different courses and an alternative menu for those who had requested specific food preferences and the chef had all the food preferences forms in the kitchen. There was also an easy to read form people were encouraged to complete about their mealtime experience. We observed that staff provided appropriate support to people who needed assistance with their meals.

Care plans contained information on specific dietary needs, preferences and allergies. People had an individual nutritional assessment and a weekly or monthly check on weight. Staff told us that if people's weights changed significantly, they referred them to the health professionals. They told us that if people found it difficult to eat or swallow then advice was sought from the dietitian or the speech and language therapist (SALT).

People received ongoing healthcare. Each person had a GP who visited weekly and as required to provide medical care. Records showed also that staff referred people to healthcare professionals when needed so that people can access suitable treatment.

All people's rooms and communal areas we saw were spacious, personalised and well maintained. We noted there was equipment such as hoists, wheelchairs, air mattresses for people to use. The service was divided into five units and each of these had a dining room and a lounge people could use.

Good

Is the service caring?

Our findings

People and their relatives told us the staff were caring. One person said, "Staff are very caring. They have got loads of patience. They are all friendly and talk to me." Another person told us, "I don't come out of my room, but I don't feel lonely. There is always staff coming in or out. They are caring." A relative told us, "The staff are lovely. They really are nice. I get on with them." Another relative said, "Staff are nice and always giving cuddles."

Staff promoted people's independence. One person told us, "I do a lot of things [by myself]." We noted staff encouraged people to undertake their own personal care tasks when they could, and to carry out tasks such as organising their rooms, using appropriate equipment and accessing communal areas within the units. Staff told us that they gave people choice, encouraged them to be as independent as possible whilst also providing them with appropriate care. One person told us staff assisted them if they needed help with personal care.

Staff told us they liked their work and the people they supported. One member of staff said, "I have worked here for nearly [a number of years] and I love it here." Another member of staff told us, "I know the residents [people], I like caring for them." We observed that people joked and laughed with staff. We saw staff attended to people, listened to them and were not hurried when, for example, supporting them with meals.

Staff were aware of people's communication needs and life histories, and interacted appropriately when assisting them. Staff told us people's histories and how they supported them following their care plans. People's care plans contained information ["My life before you know me"] which detailed people's life background including their family, childhood, and what they did for living. It also contained detailed information about people's needs that included mobility, pressure sores, speech and communication, social, oral hygiene, eating, drinking and eye sight. Information about how the needs could be met was also given so that staff knew how to support people.

People told us that staff respected their privacy and treated them with dignity and we observed people being treated with respect at inspection. One person said, "Staff respect my privacy and dignity. They are caring and they treat me with respect." We observed staff knocked on the doors and called people's names, even when the doors were left open, to ask for permission to enter rooms.

Relatives told us that they were made "welcome" when they came to the home and that they could visit any day that suited them. They told us they liked the open policy of the service and the staff. They said staff updated them with information about their loved ones and listened to them.

End of life care at the service was managed well with the evidence in care files that people's preferences about this were recorded. We noted that staff had discussed with people or representatives and recorded 'Do Not Attempt cardiopulmonary Resuscitation (DNACPR)' in some people's files. A CPR carries risks of adverse effects such as rib fractures, rupture of the liver or spleen and possibly prolonged artificial ventilation and there are situations where CPR would be inappropriate. Where people, or their families or

clinicians may opt not to have CPR, people's records are marked with DNACPR.

Good

Is the service responsive?

Our findings

People and relatives' experience of how people were supported with accessing various activities were mixed. Most people told us they were satisfied with the activities provided at the service. One person said, "There are activities but I don't go to them." However, one relative told us that they were concerned because there were "no residents' trips or outings. [My relative] has nothing to do, [they just sit] in their room all the time..., [they were] sitting outside in the corridor yesterday at the nursing station but this was a surprise. Staff could do more to engage [them]". Staff told us people chose to stay in their rooms or did not want to take part in group activities. While this was the case for some people we spoke with, we recommend that the provider consults people and their representatives and provide them with appropriate activities so that they are engaged.

Staff told us and records confirmed that there were various activities organised for people. We saw activities programmes were displayed on noticeboards in each of the units. People and staff told us a person from a faith group and a hairdresser regularly came to the service. We noted that people had different activities including a nail therapy and a dog therapy.

The acting manager told us and we saw that a quiet room, known in the service as the Namaste room, was being planned and nearly completed to be used for "pampering" on a one to one basis and giving people a quiet place to sit. There were two permanent activity coordinators but one was temporarily covered due to being on sick leave at the time of inspection. We saw programmes of activities in the units and noted that external entertainers, people from local faith groups and a trained dog came to the service. This showed various activities were available to people.

People's files showed that their assessment of needs had been completed before they came to live at the service. We noted different forms of care plans were used but the acting manager told us they were introducing a system whereby a newer version of care plan was used for all people. This newer format of care plan, which was being phased in, included life history, hobbies, likes, fears, strengths, personality and family and had a person focussed plan of care looking at issues such as anxiety, low mood, behaviour, eating and drinking, skin, person care, mobilising, capacity and maintain a safe environment. The older type of care plans included 'things I am able to do',' things I would like you to help me with', 'what we need to agree on' as a way of guiding staff in caring for people. Staff told us they read the care plans and knew people's needs. One member of staff described one person's needs and told us how staff should support them to meet their needs.

People told us staff responded promptly. One person told us staff came when they needed them. They said when they pressed their buzzer, staff came to support them quickly. We tested the buzzer from a person's room and noted staff came to check on them without delay. This showed that staff responded effectively to people's needs.

People and relatives told us they had attended meetings and shared their views with the acting manager. We noted a range of issues including how to support people trips and activities were discussed in the

meetings. People and relatives also told us they knew how to make a complaint if they were not happy about the service. They told us they could talk to staff if they were concerned about their care. We noted the complaints procedure was available to people and relatives. Records showed that eleven complaints had been recorded, investigated and responded to since the last inspection.

Good

Is the service well-led?

Our findings

People, relatives and staff talked positively about the management of the service. One person said, "I like the manager. I can chat to the manager." Another person told us, "The manager is approachable." A relative said, "The home is well led. I can go straight to [the manager] and I have found [them] to be very approachable. [They are] a new manager … is a hard worker and … wants to make this home work." Another relative stated, "Since [the new manager has been here] more staff are staying and settling. The new manager doesn't shout at staff, if [they] have issues with staff, [the manager] takes them to one side and speaks to them." A third relative told us, "The manager is really trying to get things going. I have been to family meetings and [our concerns] have been taken on board. The manager has always got time for relatives. [They listen]". One member of staff said the manager "listens" and continued to state: "The thing I like about the manager is if someone [a member of staff] is going off sick, straightaway [the manager] calls a permanent member of staff or agency to cover shift; before it was not like that." Another member of staff told us, "The manager is a nice person….always makes sure everything is well, if I have a problem I can tell [them] and [they] will listen. Staff morale is good"

Monthly staff meetings and 'flash' meetings took place. The flash meetings were daily meetings which staff had within the units to discuss significant issues at the beginning of each shift. One member of staff told us that they had attended the flash meetings and commented on the monthly staff meeting, "I have a team meeting once a month and we talk about residents, appraisals, concerns, and people's health." We also noted that the acting manager had taken action such as split time meal following the residents and families' meetings.

During the inspection we observed that the acting manager was available to people, relatives and staff. We saw a relaxed and friendly interaction between the acting manager people, relatives and staff. We noted this was a positive change within the service. We also noted a deputy manager supported the acting manager in the day- to-day running of the service. The service was divided into units each of which had a team leader and care staff who knew and understood people's needs. We were encouraged by the transparent and open attitude of the regional manager and chief operating officer to accept feedback and to tell us that they were ready to listen to the stakeholders and make any improvements needed to the service.

We found quality monitoring systems and processes were comprehensive. There were systems for gathering, recording and evaluating information about the quality and safety of care and support provided. The management and care staff did monthly audits of accidents and incidents in order to identify any trends, for example environmental hazards. Medicines audits were undertaken to check gaps in administration, storage and recording of medicines. This showed there were systems to identify and address risks.

Health and safety audits and checks were carried out in areas such as the condition of the premises, fire equipment, fire doors and water temperatures. The maintenance person told and showed us records and certificates to confirm that regular health and safety checks were undertaken and maintenance carried out as needed. The service used survey questionnaires to gather formal feedback from people and their relatives. We noted the outcome of the latest completed survey questionnaires, which had been received

from people and their relatives, was being discussed in meetings with the stakeholders. The acting manager told us that the service would develop an action plan as a response to the feedback received through the survey questionnaires.

The previous registered manager had left the service and the new manager had applied to register with the Care Quality Commission. The provider had informed us of the management changes that took place within the service. This included the allocation to the service of a new regional manager and chief operations officer. The provider had also sent information relating to notifiable incidents which they are required by law to tell us.