

Rosecare Limited

Richmond Court Care Home

Inspection report

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Date of inspection visit:
20 July 2017
21 July 2017

Date of publication:
27 December 2017

Ratings

Overall rating for this service

Inadequate 

Is the service safe?

Inadequate 

Is the service effective?

Requires Improvement 

Is the service caring?

Requires Improvement 

Is the service responsive?

Inadequate 

Is the service well-led?

Inadequate 

Summary of findings

Overall summary

This inspection was unannounced and took place on 20 and 21 July 2017. At the last inspection in April 2016, we found the provider was meeting regulations but improvements were required in relation to staffing levels.

Richmond Court Care Home is registered to provide accommodation for up to 30 older people, some of whom are living with dementia, who require personal care and support. On the day of the inspection there were 23 people living at the home. There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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.

Risks were not consistently assessed or managed which meant some people were at risk from avoidable harm. Where incidents had taken place, people's care plans and risk assessments had not always been reviewed or updated and action had not always been taken to mitigate the risk of future events. Although staffing numbers were sufficient to meet people's basic care needs staff were not always deployed in a way that meant people's care and support needs were met in a timely way. People received their medicines as prescribed and systems used to manage medicines were safe. People told us they felt safe and staff knew how to report concerns for people's safety.

The provider had not acted lawfully when seeking people's consent for care and support. People's capacity to make certain decisions had not been assessed or recorded and care records did not reflect how decisions had been made in people's interests. Staff did not always have the skills and knowledge to provide people with safe, consistent care. People were not always offered a choice of meals and records used to monitor risks to people's hydration were not completed accurately, which may place them at risk. Where people required support from relevant health care professionals, this was not always identified and referrals were not always made in a timely way.

While most people felt staff were kind and caring we observed a number of interactions and practices which demonstrated people's dignity was not always maintained by staff who supported them. People told us they were not always involved in day to day decisions about their care. Where people had specific cultural needs staff were aware and people received food specific to their dietary preferences.

People did not receive care that meet their individual needs. People were not supported to have choice and control of their daily lives and were not encouraged to make decisions that reflected their preferences. There was a feeling of resignation amongst the people we spoke with who felt staff made choices on their behalf which had a detrimental effect on the quality of their lives.

People were not supported to take part in activities or hobbies that interested them. There were minimal

opportunities for engagement available to people which meant people did not receive person centred support. People and their relatives had been involved in the assessment, planning and review of their care. People and relatives knew how to complain if they were unhappy about any aspect of their care and support.

Systems used to monitor the quality of the service had not been fully effective at driving improvement or identifying concerns. People continued to be placed at risk of harm as the communication systems within the home were not effective in ensuring risks or changes to people needs were escalated by the registered manager. As a result action had not been taken to mitigate future risk to people's safety. Improvements were required to the environment of the home in order to make it more 'dementia friendly'.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

During the inspection we found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. 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?

Inadequate 

The service was not safe.

Risks had not been assessed and/or managed to reduce the risk of avoidable harm. Action had not always been taken in response to incidents and injuries to protect people from future harm.

Staff were not always effectively deployed to ensure people received timely support with personal care or pastimes.

People received their medicines as prescribed, and systems used to manage medicines were safe.

People felt safe and were supported by staff who knew how to report concerns for people's safety and well-being. However these concerns had not always been escalated appropriately by the management team.

Is the service effective?

Requires Improvement 

The service was not effective.

People were not always asked for their consent before care was provided.

People's capacity to make decisions about their care and support had not always been assessed, which meant decisions made may not be in their best interests. Some people had their rights restricted unlawfully.

People were not always offered a choice of meals, and records used to monitor risks to people's hydration were not completed accurately, which may place them at risk.

Where people required support from healthcare professionals to manage their health needs, referrals had not always been made in a timely way, which placed people's health at risk.

Staff received training relevant to their role but did not always support people in a way that reflected their individual needs.

Is the service caring?

Requires Improvement 

The service was not always caring.

People did not always receive dignified support from staff.

People were not always given the opportunity to be involved in day to day decisions about their care.

We observed occasions where people received personal care based on an established staff routine rather than in response to their individual needs.

Visitors were welcomed in to the home and staff knew them by name.

Is the service responsive?

Inadequate 

The service was not responsive.

People did not receive care and support that reflected their individual needs and preferences.

There was a task focused culture within the home, which meant people had a lack of choice and control over their daily lives.

People were not supported to partake in activities or pastimes relevant to their individual needs and interests.

Where possible people and relatives had been involved in the assessment and planning of their care and support.

People knew how to raise concerns if they were unhappy about the care they received and there was a system in place to manage complaints.

Is the service well-led?

Inadequate 

The service was not well-led.

Systems developed by the provider to monitor the quality of care people received were not effective in identifying the issues highlighted during the inspection.

People continued to be placed at risk because information about serious incidents or risks to people's health, safety and well-being had not been addressed by the registered manager.

Although the provider had sought some feedback from people and staff there was little evidence to suggest this had been used to drive improvements.

Richmond Court Care 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 is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection was prompted in part by notification of concerns raised by the local authority who had visited the home in response to a whistle-blower who had contacted us. Whistleblowing is the term used when someone who works for an employer raises a concern about malpractice, risk or wrongdoing, which harms, or creates a risk of harm to people who use the service.

The inspection included an early morning visit to enable us to see how people were being supported by night staff. The inspection took place on 20 and 21 July 2017 and was unannounced.

The inspection team consisted of 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 use this type of service. As part of the inspection we looked at the information we held about the service. This included statutory notifications, which are notifications the provider must send us to inform us of certain events such as safeguarding concerns, serious injuries and deaths. The provider had sent us a Provider Information Return (PIR) before the inspection. A PIR is a form that asks the provider to give key information about the home, what the service does well and improvements they plan to make. We also contacted the local authority and commissioners for information they held about the service. This helped us to plan the inspection.

During the inspection we carried out observations of the care and support people received. We used the Short Observational Framework for Inspection (SOFI) to observe how care was provided for people who were unable to speak with us. We spoke with 12 people who lived at the home, two relatives, one healthcare professional, five staff members, the deputy manager, the support manager, the registered manager and also the provider. We looked at eight records about people's care and support, three staff files, medicine records and systems used for monitoring the quality of care provided including accidents and incidents.

Is the service safe?

Our findings

We looked at how risks were managed in order to protect people from avoidable harm. We found that risks to people's safety and well-being had not always been consistently assessed or reviewed. This meant people were not protected from the risk of harm and one person had been injured because staff had not taken steps to protect them. We found that while there were risk assessments in place, these did not always contain accurate information. For example, records showed that one person had, on two occasions, been found by night staff with their leg wedged between the bedrails on their bed. This could have been prevented by the use of a bumper, which covers the gaps between bedrails. No bumpers were in place at the time of the first incident and staff had also reported that the bedrails were broken. The person's risk assessment, which offered guidance to staff about how to safely support the person, had been reviewed by the registered manager following the first incident and this stated that bumpers should be place. However, a second incident occurred, almost one month later, where the person was found by night staff with their leg wedged between the bed rails again. We checked on the day of the inspection to see if bumpers were in place and found they were not. We asked a staff member about the use of bumpers on the person's bed and they told us, "I've never seen a bumper on this bed." We saw that prior to the first incident and for the period of time between the two incidents, staff repeatedly reported that the bed rails were broken and required repair. However, the only recorded repair that took place was two days after the second incident which meant the person had not been protected from risk.

We discussed our concerns about this person's safety with the registered manager who told us the gap between the bed rails was small and they had been unable to fit bumper protectors to this bed due to its style. However, later that day they advised bumpers, which were being stored at the home, had now been fitted to the bed to protect the person from future harm.

We observed another person who had swallowing difficulties and had been visited by a healthcare professional who had advised they should have their drinks thickened to reduce the risk of choking. We observed this person being supported by staff to drink and saw they were coughing or spluttering when drinking. We checked their drinks and found they had not been thickened. Staff had not followed the advice given by the healthcare professional and the person had not been protected from the risk of choking or other health risks such as aspirational pneumonia.

We reviewed records of people's weights to see how people who were at risk of malnutrition were supported. We found that records did not always reflect people's current needs and concerns about people who had lost weight had not always been appropriately escalated or referred to the person's GP. For example, we saw one person had lost weight over a period of three months, and it was only as the weight loss continued into the fourth month that the registered manager made a referral to the person's GP. We saw that systems used to monitor people's weight and risk of malnutrition were not always completed correctly. This placed people at risk of not receiving the right support to maintain a healthy weight when they needed it.

We saw people who required support with their mobility were moved in a way that increased the risk of

injury to them. On the first day of the inspection we saw people being hoisted in an unsafe way. On each occasion the sling being used was too large for the people being supported. We asked the registered manager how they had assessed which sling should be used for each person and they told us they had conducted their own assessment. On the second day of the inspection we saw a second sling had been introduced that staff used when supporting people using the hoist.

The provider had not ensured that risk assessments relating to the health, safety and welfare of people had been assessed, reviewed or followed. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Safe care and treatment.

People told us staff were available to support them throughout the day and most people felt staff responded promptly to call bells. One person told us, "I don't wait long and I can use my buzzer." We observed staffing levels throughout the two days of the inspection and found there were sufficient numbers of staff to respond to people and meet people's care needs, however they were not always deployed in a way that meant they responded quickly to people's requests for assistance. We observed one person who asked staff to support them with personal care, each time the person asked they had to wait for staff to respond. The person told us, "I don't know why staff haven't come back; I asked them for help to get to the toilet." Where people who spent time in their room used their call bells to indicate they required assistance from staff, these were answered promptly. However, throughout the inspection people told us and we observed that there was very little support available from staff for people to take part in activities and pastimes. Although there were enough staff available to respond to people's care needs, staffing was not sufficient to ensure people always received support in a timely way or that they received support to take part in activities that interested them.

We reviewed staff recruitment records and saw the provider had conducted recruitment checks prior to staff starting work at the service. Reference checks, identity verification and Disclosure and Barring Service (DBS) checks had been completed for two of the three people whose files we reviewed. DBS checks help providers reduce the risk of employing unsuitable staff. However, we found the provider had not obtained appropriate proof of employment for the third staff member. The registered manager told us they would take immediate action to rectify this.

People told us they felt safe and comfortable living at Richmond Court. One person told us, "I feel safe." Another person said, "I feel safe, it's nice enough here." We saw people were confident to approach staff if they needed assistance. Staff understood their responsibilities in recognising and reporting suspected abuse and knew how to raise concerns with both the manager and other external agencies if necessary. One staff member told us, "Firstly it's about protecting the person and then I would report any concerns to the deputy or registered manager. If they did not act I would contact the police or CQC." However, records we looked at showed that when safeguarding incidents had occurred, the registered manager had not always reported these to the relevant agencies for investigation. For example, when a person sustained injury from becoming trapped between their bedrails. This meant people may not be protected from future harm.

People received their medicines on time and as prescribed by their GP. Care plans provided staff with guidance to ensure people took their medicines safely and as prescribed. Staff told us they had been trained to support people safely with their medicines. The deputy manager also carried out competency checks on staff to ensure they were safe to support people with their medicines. There were systems in place to ensure people received their medicines as prescribed which included weekly and monthly audits carried out by the deputy manager.

Is the service effective?

Our findings

People who were able to speak with us expressed mixed views about whether they were asked for their consent before staff provided them with care and support. One person told us, "They [staff] don't give me a choice." Other people expressed more positive views telling us that staff involved them in their care. Throughout the inspection we saw examples where people were not given the opportunity to consent to their care. When we arrived at the home early in the morning eight people were sitting in the lounge. Some of the people we spoke with told us they were happy to be up and awake at that time. However others told us they had not given their consent to get up, but that staff had woken them up early and supported them to wash and dress and move to the lounge area. We saw each person was seated with a tray table immediately in front of them, which may prevent them from moving if they wanted to.

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.

Although staff we spoke with had some understanding of their responsibilities in relation to MCA we found the provider had not always carried out assessments of people's capacity to make certain decisions and care records did not reflect how decisions had been reached. For example, we observed one person who lacked capacity to make a decision about how their drinks were prepared. The registered manager had not followed advice given by a healthcare professional and had instead discussed the matter with the person's relative. However, the registered manager was not aware if the relative had the legal right to make decisions on behalf of the person and there was no evidence to suggest how the decision had been reached, or whether it was in the person's best interests.

We reviewed people's care records in relation to their capacity to consent to certain aspects of their care and found staff and the registered manager had, on some occasions, signed people's records on their behalf to indicate they had consented to care. This demonstrated a lack of understanding about people's right to consent to care and meant people may be placed at risk of being prevented from making their own decisions, should this be possible. People's rights were not upheld by the effective use of the Mental Capacity Act 2005 and the principles of the Act were not followed.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Need for consent.

We shared our concerns with the provider, the registered manager and the support manager who told us they would review people's capacity to make specific decisions relating to their care.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are

called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. We reviewed the care records of people living at the home who were currently deprived of their liberty and found there were no conditions applied to the authorisations. However, where people were being deprived of their liberty by staff in order to protect their health and well-being, we saw the appropriate applications for authorisation had not always been submitted to the local authority. During the inspection we identified a number of people living at the home who potentially had their rights restricted but the registered manager had not applied to lawfully deprive them of their liberty. We asked the registered manager if they were awaiting the outcome of any DoLS applications and they told us they were not.

Following the inspection the provider told us they had reviewed people's care and had identified a number of people who may be deprived of their liberty. The provider told us applications to lawfully deprive people of their liberty would be submitted to the local authority. We will monitor the effectiveness and sustainability of this at our next inspection.

People expressed mixed views about the food and drink provided. One person told us, "I like the food but it's not always very exciting." A second person said, "We have what they [staff] give us." We found no menus were available to people before or during lunch and staff brought people plated meals and did not always offer people a choice of meal. Where people required assistance with eating, this was provided by staff, who gave people the time they needed to eat their meal. However, we observed that for most people lunchtime was a functional, rather than a positive experience. For example, people ate food that had been brought to them by staff who had not involved them in choices about their meals. There was minimal conversation between people who were being supported with their meal and staff, which meant some people had a poor dining experience.

We saw drinks were available throughout the day, and some people, in one of the lounge areas, were offered a choice of desert after their lunch; however others were not. We reviewed records relating to people's food and fluid intake which could be used to ensure people maintained their health. However, we found that although staff were recording people's fluid intake, these records were not always completed accurately or analysed effectively in order to identify if or when any further action was required. This meant that people were not protected from the risk of avoidable conditions relating to their hydration. We shared our concerns about this with the deputy and registered manager who told us they would make changes to the current recording system to ensure people's records were accurate in the future. We will monitor the effectiveness and sustainability of this also at our next inspection.

Most people we spoke with were not able to share their experiences of staff assisting them with their day to day health needs or helping them to access healthcare professionals when required. However, one person did tell us, "If I need to see the doctor, staff will sort it for me." We saw from records that healthcare professionals such as GPs and district nurses had been involved in people's care. However some people's records reflected there had been a delay in them receiving appropriate medical support as the registered manager had not always escalated concerns in a timely manner. For example, we reviewed one person's records which reflected they had developed areas of sore skin. Staff had recorded the person's skin was red and blanching for a number of days, however these concerns had not been referred to the district nursing team for further advice and treatment. Another person had consistently lost weight, but there had been a delay in staff contacting their GP.

We shared our concerns about people's health with the registered manager who told us there was an escalation procedure detailed in each person's care records for staff to follow if they identified concerns about people's health. However, staff we spoke with were not aware of this. This placed people's at risk of

receiving inconsistent care that may be detrimental to their health and well-being. Following the inspection the provider told us they had referred four people to their GP due to weight loss and had reviewed the frequency of people's weight monitoring. We will monitor the effectiveness and sustainability of this too, at our next inspection.

During the inspection we spoke with a visiting healthcare professional who told us, "The staff are always very helpful and I can see they are making an effort to improve."

People and relatives told us they felt staff had the knowledge required to meet their care needs. One relative told us, "From what I've seen staff meet the basic care needs of the residents." Staff we spoke with told us they received training relevant to their role which they felt gave them the skills and knowledge required to support people. One staff member told us, "I've received quite a lot of training; I did moving and handling training recently which made me consider how I reassure people when using the hoist." Another staff member said, "I did first aid training recently, this was a practical session, I found it helpful." Although staff were happy with the training they received improvements were required to ensure they supported people in a consistently effective and safe way, particularly when using the hoist and when assessing people for the right equipment.

Staff told us they received an induction when they first started working at the home and were able to speak with the registered manager if they had any additional training needs.

Is the service caring?

Our findings

Most people we spoke with told us they felt staff were caring in the way they supported them. One person said, "The staff here are good, they are nice enough." Another person told us, "Staff are very good, anything I want, they help with." We observed some positive and caring interactions between staff and people. For example, one person was laughing and joking with staff about their breakfast and we saw some staff moved to people's eye level when talking to them and used reassuring touch to communicate warmth and reassurance. However, while we saw that individual staff were kind and caring towards people, the provider's systems and processes did not always ensure that people were cared for safely. For example poor risk management placed people at risk of harm. In addition staff did not consistently escalate concerns about people's health, or follow instructions from health care professionals in respect of meeting people's needs.

During the inspection we saw examples where staff did not respond to people who were in discomfort. We spoke with one person who expressed to us that they were cold. They told us staff usually asked if they wanted additional clothing but they had not done this today. The person would have been dependent upon staff to support them to dress appropriately. On two occasions during the inspection the person told us they were cold so in the absence of staff a member of the inspection team offered the person a blanket, which they happily accepted.

We saw staff did not always act in a way that was respectful or dignifying. For example, we observed one staff member entered the lounge and pointed at three people saying loudly to their colleague, "These three are for toileting". This demonstrated people's dignity was not always respected. However, we did see other examples of staff maintaining people's dignity in the way they supported them with their care needs. For example ensuring bedroom and bathroom doors were closed when in use. We also saw staff knocked on people's doors before entering their rooms.

People we spoke with did not feel involved in decisions about their day to day care and support. We found many of the people we spoke with expressed indifference and an acceptance that staff made decisions on their behalf. We found that people followed the routines established by the staff team and were not always given options about their daily living. For example, we found people did not always get to choose where they spent their time, or what time they got up.

Staff we spoke with were aware of people's cultural needs. Foods were available which reflected people's dietary preferences, for example, a vegetarian meal was available. Staff were aware of people's preferences, although this was not always reflected in the care people received. Visitors were present at the home throughout the inspection and were welcomed by staff who knew them by name. One relative told us, "We can visit any time."

Is the service responsive?

Our findings

We found people living at Richmond Court received care that failed to recognise their individual needs and preferences. There was a culture of institutionalised care, which meant people's choices, interests and decisions were not always respected. Where people's needs changed, the provider's systems had failed to ensure people received care that was responsive to those changes. Where staff members had reported changes to people's needs or raised concerns, action had not always been taken to review and update people's care; which meant some people received care that did not meet their needs. The provider and registered manager had not ensured people were adequately protected from the risk of receiving care that failed to meet their individual needs.

Throughout the inspection people expressed a lack of involvement in decisions about their care and support. People told us they were not offered choices and did not feel involved in their care. We observed the staff followed routines, which meant some people only received support with their personal care when staff offered it. A weekly planner was on display in the communal corridor which detailed times at which people would be supported with their personal care. This demonstrated a task led approach and a lack of people's involvement in decision making.

We found there was a feeling of resignation from some of the people we spoke with, who told us staff made decisions on their behalf and they just had to accept them. There was a culture of institutionalised care which meant staff made decisions about key aspects of people's daily living including when people got up, where people spent their time, what people ate, and when people received support with their personal care. This led to people feeling disengaged, despondent and unable to make their own choices.

We found people did not always receive care that reflected their individual preferences. In particular, some people told us they were not given a choice about when to get up in the morning. One person told us, "I get up at five most days, staff like to do it that way. I'm always tired, I've never really thought about staying in bed, I just get up when staff tell me to." We reviewed two people's care records both of which stated their preferred time for getting up, was later than the time staff had woken them. We spoke with another person who was dependent upon staff to help with their mobility. We saw the person had been moved by staff from one lounge to another communal area and was sitting alone without any form of stimulation. The person told us, "Staff just put me in here. I wouldn't mind going to the lounge, but I'm ok." We found people were not asked about their preferences before care and support was provided and staff did not always act in a way that respected people's right to make their own choices and decisions.

We found people's preferences were not always considered around meal times. People told us they were not offered choices at lunchtime and instead accepted what was provided. One person told us, "Staff give us a meal; you either take it or leave it." Our observations at lunchtime confirmed that people were not always given a choice.

People were not always supported to take part in activities that interested them. In their Provider Information Return (PIR) the provider told us, "We realise that a good quality of life may be different for each

person and we aim to individualise our care and support to help people achieve what is a good quality of life for them." However, throughout the two days of inspection we saw people were offered very little stimulation and most people spent their time sitting in the communal lounge areas without anything to engage them. One person told us, "There isn't a lot to do." A second person said, "I get bored, there's nothing else to do." Most people living at the home were reliant on staff support to take part in activities that interested them. However there were very few occasions throughout the inspection where staff offered people activities to take part in. For example, some people occupied themselves by completing crosswords, chatting to others or spending time in their bedrooms. Others simply sat and passively watched people around them, or slept in their chairs. There was an activity schedule on display which indicated the activity on the first morning of the inspection was 'reading group'; however we saw no evidence of this taking place. On the second day of the inspection a singing activity had been arranged and people joined in singing songs from years gone by. However, for the majority of the time people were not engaged in activities or pastimes that interested them.

People we spoke with told us about their past employment and interests and we saw that their care records reflected this. However, although people's records reflected a person centred approach we found this information had not been used to personalise activities or involve people in group or individual interests or pastimes. Staff practices did not reflect the guidance and information contained in people's care records. This had a detrimental impact on the quality of people's lives and reduced their opportunity for mental and physical stimulation.

The provider and registered manager had failed to ensure care and treatment met the needs and reflected the preferences of people living at Richmond Court. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Person Centred Care.

We discussed our concerns about the lack of person centred care with the provider and registered manager who told us activities were usually led by a member of staff who was not currently at work. However, following the inspection they told us that time had been made available each day for senior staff to support people to take part in activities according to their individual preferences. The provider also told us the planner we had read should not be on display and understood the reason for our concerns. They told us they would work to improve the way people were involved in decisions about their day to day care and support. We will monitor the effectiveness and sustainability of this at our next inspection.

Most of the people we spoke with were not able to tell us if they had been involved in the assessment and development of their care plan. However we saw from people's care records that they and their relatives had been asked to contribute to their assessment and reviews of care. Where possible people had signed their care plans to confirm their involvement. We reviewed people's care records and found they contained detailed information about people's individual life histories. The provider told us the support manager had recently reviewed and updated each person's care plans, with the assistance of the registered manager, to ensure more detailed information was available to enable staff to deliver improved person centred care and support. We found that although the quality of care planning documents had improved since our last inspection, staff were not yet familiar with the paperwork, so some information was not being consistently recorded or followed. This meant some people did not receive support which reflected their current care needs.

Some of the people we spoke with were aware of how to make a complaint if they were unhappy about the care they received. One person said, "If I am unhappy I will tell staff." A relative told us, "I can approach the manager at any time." In their Provider Information Return the provider told us they had not received any formal complaints in the last 12 months. We saw the provider had a system in place for the management of

complaints and an invitation to speak with the registered manager was advertised to relatives and visitors in the entrance hall of the home.

Is the service well-led?

Our findings

The provider is required to have a registered manager in post as part of the conditions of their registration. There was a registered manager in post at the time of the inspection. However we found that they were not always meeting the responsibilities of their role. The registered manager and provider had failed to recognise the level of risk people living at the service were exposed to. They had failed to recognise that the care being provided to people was not meeting expected standards. Although systems had been implemented with the intention of driving improvements, these had not been effective in protecting people from the risk of harm and had failed to ensure the quality of care people received.

Despite the provider being made aware of poor care practices in the months prior to the inspection we found they had not taken sufficient action to address these concerns. This meant people continued to receive poor quality care and support. We found the provider and registered manager had failed to recognise the poor standard of care some people living at Richmond Court had received. Although improvements had been made to the documentation around people's care plans we found these were not reflected in staff practice and therefore largely ineffective. The provider and registered manager had failed to address a task orientated culture at the home, which had resulted in some people receiving care that did not meet their needs and others not being protected from the risk of harm.

Prior to the inspection the provider had completed a Provider Information Return. A PIR is a form that asks the provider to give key information about the home, what the service does well and improvements they plan to make. While the PIR offered some information about the service, we found in some areas it lacked detail or did not give an accurate reflection of the service. In their Provider Information Return the provider told us, "Staff understand and have a good working knowledge of the Deprivation of Liberty Safeguards and the key requirements of the Mental Capacity Act 2015." However, we found the registered manager and staff team were unclear about their responsibilities in relation to MCA and DoLS. This meant some people may be deprived of their liberty unlawfully.

We reviewed systems the provider used to ensure the service was safe and to monitor the quality of care provided. We saw that a range of checks were completed including health and safety audits, fire checks, staff spot checks and medicines audits. Although quality assurance systems were in place to identify areas for improvement; these systems had failed to identify the issues we found during the inspection. For example, the registered manager maintained a log of accidents and serious incidents. However, although some of the events we identified during the inspection had been reviewed by the registered manager, the actions detailed in response to these incidents had not been carried out. For example, after one person got their leg wedged between the bed rails, the follow up action recorded to protect the person from future harm had not been completed. This meant the person had not been protected from the risk of harm.

The provider's communication systems had not been effective in ensuring all information about people health, welfare and safety had been shared with management team for further escalation or referrals to relevant healthcare professionals. This meant that where some people were losing weight, or had developed sore skin, timely action had not been taken to mitigate future risk. This placed people at risk of avoidable

harm.

The provider had not established systems to ensure risks to people were effectively assessed and reviewed. We found the risk assessments did not always reflect people's current care needs, which meant staff knowledge of the risks people faced was not consistent. For example, when supporting people with swallowing difficulties with food and drink.

In their PIR the provider told us, "There is also a quality assurance system in place to ensure that every aspect of the service is audited to ensure that a quality service is being provided and all aspects of health and safety are being met." However, we found audits conducted by the registered manager and support manager were ineffective at identifying concerns. For example, the action plan provided to us and the local authority in response to the concerns identified earlier in the year did not accurately reflect the actions taken in relation to fluid charts, pressure care and people's capacity to make decisions about their care. We found the PIR did not give an accurate reflection of the home and the provider had failed to identify areas of the service that required significant improvement.

The provider did not have effective systems in place to assess, monitor and improve the quality and safety of services provided. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Although most people we spoke with were not able to share their views on the management of the home with us, because of their needs, they did tell us they could approach the staff team at any time with queries or concerns. One person told us they would speak to the provider if they wished to share their views. People had been invited to attend a resident's and relative's meeting which was held every six months and we saw menus had been discussed at the most recent meeting in June 2017. We reviewed the provider's quality assurance records and found people had been given an opportunity to respond to a questionnaire about life at the home. We saw from the nine questionnaires completed, five people had raised concerns about the lack of activities. The provider told us they had advertised for a new activity co-ordinator in response to these concerns but no interim measures had been implemented to address the shortfalls.

Staff expressed mixed views about whether they felt the home was well managed, but they told us they could share their views or concerns with the management team. One staff member told us, "The registered manager is very nice; I feel I can go to them with any concerns." Another staff member said, "I can talk to the manager or deputy if I need to, I wouldn't have a problem approaching them." However, other staff expressed dissatisfaction about how the management team responded to their concerns. One staff member told us, "I'd say about 50% of concerns are addressed by the management team, with other concerns nothing seems to happen." A second staff member said, "I have voiced opinions in the past, sometimes I feel listened to, and other times I don't. I'm not frightened to vocalise my views though." We reviewed results from a recent staff survey which indicated some staff had raised concerns about poor communication and information sharing within the home. The registered manager told us this would be discussed at the next staff meeting.

During the inspection we identified a number of improvements were required to the environment of the home. For example there was a strong smell of urine in some parts of the home. A high number of people residing at Richmond Court were living with dementia; however there was limited dementia friendly signage throughout the home, which may mean people could struggle to find their way around. Other information which could be useful to people living at the home had not been made available in easy read or visual formats, for example, menus or activity options.

Prior to and following the inspection we reviewed the information we held about safeguarding and serious incidents within the home. We found that the provider had completed appropriate notifications about incidents and events that had taken place. A statutory notification is a notice informing CQC of significant events and is required by law.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider and registered manager had failed to ensure care and treatment met the needs and reflected the preferences of people living at Richmond Court.

The enforcement action we took:

Positive Condition

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had failed to ensure people's rights were upheld by the effective use of the Mental Capacity Act 2005.

The enforcement action we took:

Positive Condition

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 risk assessments relating to the health, safety and welfare of people had been assessed, reviewed or followed.

The enforcement action we took:

Positive Condition

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have effective systems in place to assess, monitor and improve the quality and safety of services provided.

The enforcement action we took:

Positive Condition