

Methodist Homes Richmond

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

Richmond is located in Bexhill-on-Sea and provides accommodation and personal care for up to 58 older people requiring support with a dementia type illness and who are at risk of falls and long term healthcare needs such as Parkinson's. The home is set out over two floors. There is lift access between the ground floor and upper level. At the time of our inspection there were 49 people living at the home, one of whom was in hospital.

Richmond was inspected in March 2017. A number of breaches were identified and the service was rated requires improvement with the well led domain rated as inadequate. We served a number of Requirement Notices in relation to meeting people's preferences, providing support in line with the Mental Capacity Act, unsafe medicine procedures, not reporting possible abuse effectively, inadequate systems for assessing and monitoring the service and insufficient staff levels. Following our inspection the provider sent us an action plan telling us how they would make improvements. This inspection found improvements had been made in several areas but in relation to the management of 'as required medicines and the overall assessment of staff levels there were still shortfalls that needed to be addressed to fully meet the regulations. We acknowledge the management structure had changed following the last inspection and there had been difficulty in staff recruitment.

There was no registered manager in post. 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 associated Regulations about how the service is run. A manager had been appointed and was in the process of submitting their application for registration. Since our inspection we have received this application and it is currently being processed.

There have been a number of changes to the management of the home in the past two years. In recent months CQC have received a number of concerns about the service and where appropriate, these have been sent to the local safeguarding team for investigation. During our inspection we received concerns from two whistle blowers (WB). Immediately following our inspection a third WB contacted us. Concerns included poor record keeping, a lack of availability of some prescribed creams and poor care. We looked at some of the concerns raised and asked the provider to carry out an investigation. We found some of the concerns were substantiated. However, a number of concerns were historical and actions had already been taken to address these areas.

The management team confirmed staff turnover had been high and in a number of cases disciplinary actions had been taken. This had led to low staff morale. The management team had responded robustly to this and to the impact this had on the running of the home and the care and support people received. Feedback from staff, visitors and people confirmed significant improvements had been made in relation to the running of the home.

Whilst we found improvements had been made we also found there were areas where improvements were needed. For example in relation to the management of medicines prescribed on an 'as required basis,' in relation to monitoring of mattress settings to ensure people's skin integrity, and in consideration of risks when caring for people whose behaviour can challenge.

There were particular times of the day when calls bells were busy and this had an impact on people and staff. Whilst there were systems to monitor this, they needed to be implemented more frequently to ensure people's needs were met safely and if necessary to revise staff levels. Systems for monitoring staff levels also needed to take account the overall impact of a high use of agency staff and a high number of falls.

Despite the above concerns we found staff understood what they needed to do to protect people from the risk of abuse. Appropriate checks had taken place before staff were employed to ensure they were able to work safely with people at the home.

The manager and staff had completed training on the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. They had assessed some restrictions were required to keep people safe for example, doors were locked and, where assessed as appropriate bed rails and mat sensors were used for people's safety. Where this was the case referrals had been made to the local authority for authorisations.

People had access to healthcare professionals when they needed it. This included GP's, dentists, community nurses, and opticians.

People were asked for their permission before staff assisted them with care or support. Staff received regular support from management which made them feel supported and valued. They were encouraged to develop their skills and take on additional responsibilities. Staff spoke positively about the changes made to the running of the home and the way the home was managed.

Staff were kind and caring, they had developed good relationships with people. They treated them with kindness, compassion and understanding. Staff supported people to enable them to remain as independent as possible. They communicated clearly with people in a caring and supportive manner. We received positive feedback from relatives and visiting professionals about the care provided.

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 this 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?

The service was not consistently safe.

The management of medicines prescribed on an as required basis were not always safe.

Staff understood the procedures to safeguard people from abuse.

Recruitment procedures ensured only suitable people worked at the home.

Requires Improvement ●

Is the service effective?

The service was good.

There was a training and supervision programme to ensure staff maintained current knowledge and skills.

The manager and staff had a good understanding of mental Capacity assessments (MCA) and Deprivation of Liberty Safeguards (DoLS).

People were given choice about what they wanted to eat and drink and received food they enjoyed.

People were supported to have access to healthcare services and maintain good health.

Good ●

Is the service caring?

The service was good.

People were treated with respect and dignity.

Staff knew people well and treated them with kindness and warmth.

Staff adapted their approach to meet people's individual needs and to ensure care was provided in a way that met their particular needs and wishes.

Good ●

Is the service responsive?

The service was good.

People received support that was responsive to their needs because staff knew them well.

People were supported to take part in activities of their choice.

People's support plans contained guidance to ensure staff knew how to support people.

Good ●

Is the service well-led?

The service was not consistently well led.

Systems to assess safe staff levels needed to be monitored more regularly.

There were systems for monitoring and improving the service.

The manager was approachable and supportive and encouraged staff to develop in their roles.

Requires Improvement ●

Richmond

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 checked 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.

We visited the home on the 14, 15 and 18 September 2017. This was an unannounced inspection. 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 used this type of service.

During the inspection, we spoke with 11 people who lived at the home, five visitors, the activity coordinator, maintenance person, cleaner, four care staff, the registered manager and deputy manager. We spoke with or received correspondence from three visiting health or social care professionals.

Some people were unable to speak with us. Therefore we used other methods to help us understand their experiences. We used the Short Observational Framework for Inspection (SOFI) at lunchtime on the first day of our inspection. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

Before the inspection the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We considered information which had been shared with us by the local authority, looked at safeguarding concerns that had been raised and notifications which had been submitted. A notification is information about important events which the provider is required to tell us about by law. We also contacted the local authority to obtain their views about the care provided in the home.

During the inspection we reviewed the records of the home. These included staff training records and procedures, audits, three staff files along with information in regards to the upkeep of the premises. We also looked at six care plans and risk assessments along with other relevant documentation to support our findings. We 'pathway tracked' people living at Richmond. This is when we looked at their care

documentation in depth and obtained their views on how they found living at Richmond. It is an important part of our inspection, as it allowed us to capture information about a selected group of people living there.

Is the service safe?

Our findings

At our last inspection of the service we found the provider was in breach of Regulation 12 as there were concerns related to people's medicines and infection control. In addition they were in breach of Regulation 18 as there were not enough staff to support people. Following our inspection the provider sent us an action plan telling us how they were going to make improvements. At this inspection we found the provider was now meeting Regulation 18 but further time was needed to ensure there were sufficient suitably qualified staff deployed at all times to meet peoples' needs. Although there had been progress in relation to meeting Regulation 12 there were still shortfalls that remained a breach.

People and relatives told us their medicines were managed well. However, we found the management of medicines prescribed 'as required' (PRN) was not always safe. One person was prescribed a pain killer 'as required' four times a day. In addition, they were prescribed a tablet, 'as required' when they were anxious. Staff told us this person was often in pain in the mornings and was anxious when staff were giving personal care. The tablet for anxiety was recorded as having been given most mornings along with the pain killer. To the rear of the MAR chart there were occasions it had been recorded the person had been anxious or agitated but sometimes there was no record. The PRN protocol stated the medicine was to be given when agitated but there was no explanation of what agitated meant or the steps to be taken before giving this medicine, and this left it open to interpretation. A staff member told us both tablets were given at the same time so it would not have been possible to assess if one alleviated the pain and if the other was necessary. Equally, if it was assessed as necessary each morning this should have been discussed with the person's GP to ensure it was prescribed daily.

People told us they felt safe. A visitor told us, "We are very happy with the home, it was the best place locally, its purpose built and she is safe here." Another relative told us, "I feel he is safe as everybody is on the ball, he has had a number of falls but mostly early in the morning when he is a bit disorientated." Despite these positive comments we found examples of practices that did not demonstrate people were always cared for safely.

People's care plans contained risk assessments for a range of daily living needs such as falls, nutrition, skin pressure areas. Risk assessments included measures to protect people, such as identifying the number of staff required to support people to move safely around the service. However, risk assessment documentation in relation to the management of behaviours that challenged were less clear. Staff told us one person did not like receiving personal care in the mornings. They became agitated and records show several recent incidents where staff had been assaulted. Records stated, 'very challenging today' or 'agitated'. There was no analysis of these incidences and no risk assessment to give advice about how this person should be supported to minimise the distress for them and the risk of injuries to staff. In relation to a second person it was noted a referral had been made to the mental health team for guidance in May 2017 but the care plan contained limited advice regarding how to support the person with personal care. A visiting professional told us documentation for one person related to falls and challenging behaviour had not always been clearly recorded in the past few months.

Pressure relieving mattresses were used for those assessed at risk of pressure damage. These need to be set in line with people's individual weights and according to the manufacturer's instructions. There was no effective system to monitor settings. One person's mattress was set at 80Kgs but should have been set at 60Kgs and this left them at increased risk of pressure damage. The manager acted promptly and a new form was introduced. On the third day of our inspection we saw the form had been completed daily since introduction.

On the first day of our inspection we noted a staff member had left a hot trolley unattended in the dining room on the ground floor. The staff member had assumed it was ok to do this as the manager was in the vicinity but this had not been checked out. This left people at risk of severe burns, had they touched the trolley. We brought this to the attention of the manager who arranged for it to be removed until the staff member returned.

Possible risks to people's safety from the environment and equipment were well managed and staff carried out regular health and safety checks. This included regular servicing for gas and electrical safety. There were procedures to make sure regular and ongoing safety maintenance was completed. A fire risk assessment had been done and identified works had been completed. Personal emergency evacuation plans (PEEPs) ensured staff and emergency services were aware of people's individual needs and the assistance required in the event of an emergency evacuation. However, it was noted for one person there was a stay put policy at night time. This would not be advisable in a real fire situation as this could put them at risk if there was a delay in the emergency services arriving.

The above areas are a continuing breach of the Health and Social Care Act 2008 Regulation 12 (Regulated Activities) Regulations 2014.

At our last inspection we had concerns regarding staff levels and a poor response to call bells. Following our inspection staff levels on the first floor were increased in the afternoons. We were told this had since been decreased as there were now fewer people living there. An additional 20 hours had been increased on the cleaning side and an additional senior care worker had been employed on nights. On the day of inspection interviews were held for a part time activity coordinator. The manager had recently appointed staff to meet their night shift staff complement and they were awaiting start dates subject to satisfactory checks.

There were still 179 hours vacant on day shifts. These hours were covered through the use of agency staff. The manager told us they tried to ensure there was consistency in the agency staff used. Staff said when regular agency staff were used who knew people's needs, staff levels were sufficient. However, when new agency staff worked on shift, the routines took longer and this had an impact for people. People and their relatives echoed these comments. One person said there were, "Usually enough staff, I prefer regular staff because they know you." A visitor told us, "Since the beginning of the year there is a lot of agency staff. Mum likes to make relationships and it's difficult with the change of staff."

One person told us, "I feel perfectly safe, I like living here because it's nice to be looked after, and it's a comfort to have someone around 24 hours." Another told us, "I feel very safe and comfortable and I'm very happy." However, calls bells on the first floor were busy during the afternoons on two of the three inspection days. On the first day one person was upset because, "Bells are ringing continuously." They thought it was a problem with their hearing aid and were distressed by the continuous noise. On the second day a call bell sounded continuously in the dining room toilet for over ten minutes. An agency carer accepted the call twice but did not check the toilet. The system changed to an emergency call and the cleaner reset the call bell. The agency carer told us they could not leave others in the lounge. There was no one in the toilet area so it was not clear why the bell had been pressed. We discussed this with the manager and it was agreed

someone should have checked this area sooner to assess if this had been an emergency situation.

We agreed with the staff analysis that when the staff compliment was made up of staff who knew people well the numbers of staff were sufficient to meet people's needs. This was evident on the third day of inspection when there were no agency staff on shift and call bells were responded to quickly. However, when agency staff who were not familiar with the home were used, this slowed down the response time to people. This is an area that requires improvement.

The manager told us they had taken on the role of infection control champion. As part of this role they and a staff member were going on an infection control course the week following our inspection. Since the last inspection an audit had been carried out to assess areas that required attention. New trolleys had been bought to eliminate the need for staff to have to carry soiled laundry.

Two visiting professionals told us about a strong odour of urine in the home. We found there was a strong odour of urine at the entrance to the ground floor unit. However, we were told new carpet had been ordered and the home was awaiting the delivery of new chairs.

At our last inspection there were a number of concerns regarding the management of medicines. With the exception of the management of 'as required medicine, procedures for the management of medicines had improved. The manager told us since then the home's pharmacist had reviewed the timings of medicines to assist in reducing the length of time it had taken to give medicines in the mornings. As a result some medicines had been moved to early morning or others to lunch time or evenings. A representative of the health authority also assessed each person's medicines and carried out an audit of medicines used, to check if all medicines were required. Records showed all staff had been assessed in relation to competency with medicines management. The deputy manager told us if agency staff needed to be used they always tried to ensure they were staff who knew the home well. Staff told us measures that had been put in place worked well.

There was information in each person's care plan about how they liked to take their medicines. Medicines administration records (MAR) showed people received their medicines as prescribed. When there had been a medicine error, the staff member referred themselves to the safeguarding team and ceased giving medicines until they had received further training and competency assessment. The manager encouraged staff to report mistakes and emphasised a 'no blame' culture. Some people had been prescribed 'as required' medicines and there were protocols that provided guidance for staff about when these may be needed. There were body maps for the use of topical creams to ensure people knew where to apply the creams. A staff member told us they had difficulty obtaining a prescribed cream for one person but with the assistance of the district nurse this had been resolved. Records for topical creams showed in previous months signing had been a problem but this had been addressed and improvements noted in this area.

There was advice on staff notice boards to guide staff in whom to contact if they were concerned about anything and details of the whistle blowing policy. 'Whistleblowing' is when a worker reports suspected wrongdoing at work. Officially this is called, 'making a disclosure in the public interest.' Staff told us what they would do if they suspected abuse was occurring at the home. Staff were able to tell us who they would report safeguarding concerns to outside of the home, such as the Local Authority or the Care Quality Commission.

Staff recruitment checks were undertaken before staff began work at the home. This helped to ensure, as far as possible, only suitable people were employed. This included an application form with employment history, references and the completion of a Disclosure and Barring Service (DBS) check to help ensure staff

were safe to work with adults.

Is the service effective?

Our findings

At our last inspection of the service we found shortfalls in staff understanding of the Mental Capacity Act 2005 (MCA) and this was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Following our inspection the provider sent us an action plan telling us how they were going to make improvements. At this inspection we found improvements had been made and legal requirements had been met.

The manager told us following the last inspection mental capacity assessments had been reviewed. However, since then a new format had recently been introduced that enabled people's decisions to be more clearly recorded. These were gradually being introduced. A staff member had taken on the role of MCA champion. All of the staff had received training in MCA. Consent to care and treatment was sought in line with the law and guidance. Processes were followed to assess people's mental capacity for specific decisions, for example, in relation to the use of sensor mats or bed rails. Meetings to reach decisions on behalf of people and in their best interests were carried out appropriately.

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). All appropriate applications to restrict people's freedom had been submitted to the DoLS office as per legal requirements. The manager had considered the least restrictive options for each person. One person occasionally refused medicines. A discussion had been held with the person's family and the pharmacist to check if the medicines could be given covertly but this had not been agreed. This decision was respected.

People received effective care as staff had received appropriate training to meet their needs. Staff training included safeguarding, food hygiene, fire evacuation, health and safety and infection control. Staff completed an induction when they started working at the service and 'shadowed' experienced members of staff until they were competent to work unsupervised. They also received additional training specific to people's needs, for example wound care, dementia care, nutrition and training on equality and diversity. Additionally, there were opportunities for staff to complete further accredited training such as the Diploma in Health and Social Care. A staff member told us, "I liked not having to wait for training. It was all done before I started". They also said, "Staff have been really nice, they have been very patient with me when I asked questions."

A staff member told us they had recently completed online training on dementia. They said the trainer had suggested the use of singing to distract a person who was anxious when receiving personal care. They had not considered this technique before but recognised this might be appropriate for some people. Another staff member told us they sometimes singing as a method of helping one person to relax when personal care was provided and this was effective for them.

Staff received supervision regularly. Feedback from staff and the manager confirmed formal systems of staff development, including an annual appraisal was undertaken. Staff told us they felt well supported. One staff

member said, "We are all clear about what we have to do but I can go to any of the management if I have a problem. The care here is very good." Agency staff confirmed they were shown around the building when they came to the home first and the fire procedure was explained. The manager said they confirmed with the agency that all staff used had the training and skills to work at Richmond.

People could choose where to have their meals. A small number of people chose to eat in the lounge area but most people ate in the dining room. People were asked where they wanted to sit. There was a choice of drink on each table. The mealtime was not rushed and those who needed it were discretely supported to maintain their independence. For example, staff offered to cut food up and support with eating, if appropriate.

When risks were identified these were reflected within care plans. For example, there were charts to monitor people who were at risk of not eating or drinking enough. A target intake was recorded and each chart was totalled daily to make sure it was met. Staff told us they had difficulty ensuring one person reached their target intake and this had been discussed with the person's GP and their district nurse who visited regularly. People were weighed regularly so staff could identify if they were at risk of weight loss or malnutrition. Where people had been assessed as losing weight, appropriate referrals to the GP had been made and advice obtained. Staff told us one person who had difficulty swallowing had recently been referred back to the speech and language team for advice and support.

Is the service caring?

Our findings

At our last inspection we found the service was not always caring and required improvement in areas related protecting people's dignity. At this inspection we found issues related to dignity had been addressed.

Throughout our inspection staff interacted positively with people and spoke calmly and with respect. A visitor to the home told us, "The regular staff are patient, kind and caring." One person told us staff were, "Very kind and gentle." Another said, "I get on well with all the staff they are excellent." When people needed assistance to move from one area to another, staff explained to people what they were doing and offered reassurance throughout. A visiting professional told us, "From my observations, staff do positively engage with residents, supporting and communicating effectively. Permanent staff have a good understanding of the individual residents, personal preferences and personal histories. This also extends to the wider staff team, the domestic, maintenance and kitchen staff, all respecting and interacting with residents appropriately."

People were supported by staff that treated them with dignity and respect. Within each care plan there was advice about ensuring people's privacy and dignity was maintained and ensuring people were encouraged to make preferences in how they were supported. Staff gave us examples of how they maintained people's privacy and dignity. They said they knocked on people's doors and waited for a response before they entered the room. They told us they maintained people's privacy and dignity by always ensuring doors were closed when personal care was given. When food was served to people this was done in a way that met their individual needs and maintained their dignity. For example, staff sat at the same level as people, maintained eye contact, and they spoke with people as they provided support.

When one person needed immediate support with personal care a staff member provided a discrete explanation to the person and guided them to a private area where this was provided. Their calm and reassuring approach enabled what could have been a cause for embarrassment for the person, to be dealt with quickly and with no loss of dignity. We saw another occasion when one person's dress had become stained and staff took the person to their room changed their clothes for them.

During our inspection we observed people were treated with kindness and compassion. There was a very relaxed and calm atmosphere in the home and staff had a good rapport with people. People's relatives were encouraged to personalise bedrooms to reflect the people's individual tastes and interests. Care plans included information about people's needs, choices, personal histories and interests. For example, for one person the care plan stated, "Give time to allow her to find the correct words and use body language to help her understand." We observed staff talked and communicated with people in a way they could understand.

During the mealtime we observed staff giving people choices with their meals and drinks. They encouraged people to eat independently and support was offered and if accepted, provided in a way that suited each person. For example, some people needed gentle prompts to remind them to eat. Other's needed support to cut their food and some needed support to eat. Support was provided discretely. When one person sneezed staff immediately gave the person a tissue to maintain their dignity.

Is the service responsive?

Our findings

At our last inspection there was a breach of Regulation 9 as there were shortfalls in care plan documentation and in the provision of person centred care. Following our inspection the provider sent us an action plan telling us how they were going to make improvements. At this inspection we found improvements had been made and legal requirements had been met.

Care plans contained detailed information about people's needs in relation to personal care, mobility, skin integrity, nutrition, health and personal preferences. There was guidance for staff about how to support people with their mobility, this included the use of a mobility aids or the support of staff. There was specific information in support plans about how each person liked to be supported and if they had any particular preferences. For example, two people told us whilst happy to be supported by all staff; they would prefer to be supported by female staff for personal care. This was documented in their care plans and staff told us they tried to respect people's preferences. People said they decided what time to get up and go to bed.

Information within care plans was personal and specific to each individual. For example, one person liked to have a lamp on at night so if they needed to use the bathroom they could do so independently. This person was to sit on a pressure relieving cushion in the lounge and dining room. We noted this had not been done. Staff told us the person did not like to sit on the cushion in the dining room. In the lounge the person moved frequently which meant staff checked regularly to ensure they were sitting on the cushion. Staff were aware this was needed and attempted as much as possible to ensure this was done.

Visitors to the home told us and we confirmed through records, that relatives were invited to people's reviews. One relative told us, "We were involved with the care plan right from the start and there is a review coming up again that we have been invited to."

The activity programme included regular in-house activities. There was one part time activity coordinator and interviews were held over the course of our inspection for a second part time co-ordinator. We were told that until a new activity coordinator was appointed staff would assist with activities. We observed staff sitting with, reading to and doing exercises with staff. On the first day of our inspection the programme included a one to one outing, hand pampering and a retro film in the Richmond cinema. A film was also shown on Heatherbank. A visitor told us, "On Mondays there is music in the afternoon and every two weeks a dementia group comes in." As the home has a Christian ethos, a minister conducted a church service twice a week and held prayer meetings at other times. There was a hair salon in the home and we were told people were offered the choice of having their hair done weekly. People told us they were happy with the activities provided; they said they liked to keep busy. One person said, "I like to knit and sew." Another said, "I go to the library with my daughter every other Monday. I like to read." A third person said, "I go out with the carers on the bus and sometimes I walk around the garden."

People told us they tried to maintain their own independence. One person said, "I'm very independent I do my own personal care and shower myself. Another said, "I can have a bath or shower anytime I like but I prefer to have a strip wash, I washed my hair this morning myself and rubbed it dry." There was a chart to

record how often people had baths/showers and washes. We were told this was checked to make sure people's preferences were met.

There was a complaints policy which was displayed so visitors were clear about how they could raise concerns should they wish to. Where complaints had been made, records confirmed the details and actions taken to resolve them. A visitor told us, "We would be happy to raise any concerns if we had any." Another visitor told us, "I made a complaint that the bathroom and toilet were dirty and it was sorted straight away."

Is the service well-led?

Our findings

At our last inspection the provider was in breach of Regulation 13, and at our last two inspections they were in breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014. These issues related to a lack of reporting of safeguarding matters and to a lack of leadership and governance. Following our inspection the provider sent us an action plan that showed how they would meet the Regulations. At this inspection we found, where appropriate, safeguarding referrals had been made to the Local Authority in a timely manner and Regulation 13 was met. There was ongoing work to improve the leadership and governance of the service.

There was no registered manager in post. However, a manager had been appointed in May 2017 and they told us they were in the process of applying for registration. Since then we received an application for registration and this is currently being processed. The manager was supported by a deputy manager. Since the last inspection the area manager and area manager assistant had visited the home on a regular basis to provide ongoing advice and support.

There were some areas where ongoing work was required to ensure the smooth running of the service. Fire drills were held regularly to ensure staff knew what to do in the event of a fire. Records showed overall staff performance had improved. However, recent records for night staff drills indicated further drills were required and the most recent day drill showed a slow response time. The maintenance person stated the results of the last two drills were disappointing but there were mitigating circumstances and further drills would be carried out to address this.

Systems to review response times to call bells had been introduced and if a shortfall was identified this was investigated and an action plan was drawn up to minimise the risk of a reoccurrence. The new procedure meant ten calls would be monitored at any one assessment period. Calls over five minutes would require an investigation. Two periods of monitoring had been carried out and only one call had been over five minutes. Calls bells on the first floor were very busy during the afternoons on two of the three inspection days. The manager told us they would increase the frequency of call bell monitoring.

One person regularly sounded their call bell. This person was given support in line with their care plan. However, wording in the care plan was misleading and could have been perceived to show a lack of dignity and respect for the person. We recommended the manager discussed this further with a health professional to agree a more appropriate response to the person's wishes and needs.

Basic 'at a glance information' had been compiled to enable agency staff to read information about each person's key needs. A booklet was available in the office and on each floor for this purpose. However, we asked two agency staff if they had seen this booklet and neither had. We discussed this with the manager and new form was drawn up that ensured agency staff signed to say they had been shown the booklet.

Each person's dependency needs had been assessed in terms of high or medium need. Overall 17 people had been assessed as needing medium support and 32 high support. At the time of our inspection there was

no system that holistically looked at changes to people's needs, the impact of a high use of agency staff, high records of falls and call bell monitoring at peak times. We asked how the dependency tool was used in determining safe staff levels. We were told a meeting had been arranged to be held in October to determine how the tool should be used in relation to determining safe staff levels.

The issues above are a continuing breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Since the last inspection a large number of whistle blowing concerns were received by CQC. Where appropriate, these were referred to the local safeguarding team for investigation. Over the course of the inspection three further concerns were received anonymously. Each contained similar information. Some of these concerns were addressed during the inspection and we asked the provider to investigate further. The management team confirmed staff turnover had been high and in a number of cases disciplinary actions had been taken. This had led to low staff morale. The management team had responded robustly to this and to the impact this had on the running of the home and the care and support people received.

The organisations' human resources team had come to the home and spent three days there. They had invited staff to meet with them to discuss any concerns they had, either anonymously or openly. The manager had also introduced a 'surgery' one afternoon a week and staff and visitors were free to spend time with them to raise any concerns they might have. Formal supervision meetings were carried out and staff team meetings were arranged. We were told initially there had been some resistance to the approaches used and offered but more recently there had been a turn around. All of the staff told us they felt well supported. One staff member told us, "I like the manager; she is firm when needed and not afraid to make changes. Morale is a lot better than it used to be." Another said, "It's all coming together now, we can approach management and we are given a clear sense of direction."

Records showed heads of department meetings were held weekly along with senior staff meetings, staff meetings, residents and relatives meetings. As requested at the last relatives meeting arrangements were being made to vary the times for meetings to enable greater attendance. Minutes were open and there were frank discussions about some of the problems the home had been experiencing and what was being done to address them. Records of staff meetings also demonstrated some unrest within the staff team but over the last few months there was a steady change in the tone and content of the discussions. A staff member told us, "Staff give opinions. We never used to, but we say more now. If we say we need something we get it. For example, we asked for later breaks and this was agreed. We asked to change the lounge area and this was sorted."

The home had a designated Chaplin who provided spiritual support for people and staff. Recently the Chaplin and some relatives spent time with people newly admitted to hear their thoughts on what it was like entering and living in Richmond. The results were recorded to be used in shaping and developing the admission process for future admissions to the home.

Records were kept of all accidents and incidents that occurred. All falls were monitored closely in terms of location and time. Each accident was investigated and there were records of actions taken. Due to an increase in the numbers of falls, a referral had been made to the falls team to seek advice and support. One person had one to one support to help reduce the number of falls. Sensor mats were used where appropriate, to alert staff to the need to offer support.

Satisfaction surveys were carried out annually. The number of respondents was down from previous years. The results of the last relative's survey had been discussed at a relative's meeting in June 2017. An action

plan had been drawn up to address any matters identified through this process. Actions taken, included the increase in the cleaning staff hours and additional training for staff on privacy and dignity. The results of the last staff survey had been poor. However, this had been carried out before the current manager took their post. A number of actions were taken as stated above to address poor morale and to improve working conditions. We were told a new staff survey would be carried out shortly.

There were plans for introducing more detailed end of life care and support plans. A booklet had been compiled which included all aspects of end of life care and what should be in place to ensure the person's individual needs and those of their family could be met. We were told the booklet would be discussed with the person and their relative/representative in advance of this diagnosis and would include specific wishes.

There were systems to audit a range of areas such as medicines, medicine's spot checks, care plans, room checks, visual kitchen checks, infection control checks, activities, food safety and health and safety. Where shortfalls were identified, records showed the actions taken to address them. There were systems to ensure a clear audit trail of medicines. All medicines not included within the monitored dosage system were counted at regular intervals. A medicine's handover book was used to keep track of medicines needed and ordered.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 12 HSCA RA Regulations 2014 Safe care and treatment</p> <p>The registered provider had not protected people against the risks associated with the unsafe use of 'as required' medicines.</p> <p>The provider had not ensured the safety of service users by assessing the risks to the health and safety of service users of receiving the care or treatment and doing all that was reasonably practicable to mitigate any such risks.</p>
Accommodation for persons who require nursing or personal care	<p>Regulation 17 HSCA RA Regulations 2014 Good governance</p> <p>Regulation 17 HSCA RA Regulations 2014</p> <p>Good governance</p> <p>The registered provider did not have an effective system to regularly assess and monitor the quality of service that people received.</p>