Methodist Homes

Richmond

Inspection report

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Date of inspection visit:
08 November 2018
09 November 2018

Date of publication:
12 December 2018

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

We inspected Richmond on the 8 and 9 November 2018. This was an unannounced inspection.

Richmond is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. 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 live with 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.

Following our inspection 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. The provider sent us an action plan that told us how they would address these. We inspected again in September 2017 to check the provider had made improvements and to confirm legal requirements had been met. We 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.

This inspection found that whilst improvements seen in September 2017 had not deteriorated, there had not been the necessary improvements to change overall the rating to Good.

This is the third consecutive time the service had been rated as Requires Improvement.

Whilst the provider had progressed quality assurance systems to review the support and care provided, there was a need to further embed and develop some areas of practice that the existing quality assurance systems had missed. This included updating care plans when an identified need or directive of care changed. For example, a deterioration in health and nutritional needs.

Not all care plans had been reviewed and updated to ensure they reflected people's current needs and associated risks. For example, when a person's skin integrity changed and the equipment used to manage the risks to their skin, such as pressure reliving mattresses.

We have made a recommendation about the management of some medicines and in how staff administered medicines.

There was a 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.

People spoke positively of the home and commented they felt safe. Our own observations and the records we looked at reflected the positive comments people made.
Most care plans reflected people's assessed level of care needs and care delivery was person specific, holistic and based on people's preferences. Risk assessments included falls, skin damage, behaviours that distress, swallowing problems and risk of choking, and moving and handling. The care plans also highlighted health risks such as diabetes and leg ulcers. People said they felt comfortable and at ease with staff and relatives felt people were safe.

Staff and relatives felt there were enough staff working in the home and relatives said staff were available to support people when they needed assistance. The provider was actively seeking new staff to ensure there was a sufficient number with the right skills when people moved into the home. Pre-employment checks for staff were completed, which meant only suitable staff were working in the home.

All staff had attended safeguarding training. They demonstrated a clear understanding of abuse; they said they would talk to the management or external bodies immediately if they had any concerns. Staff had a clear understanding of making referrals to the local authority and CQC.
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. 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.

Activities were provided and were seen to be enjoyed by people who lived at Richmond. Staff told us they were constantly reviewing activities and ensuring that they reflected people's interests. Staff had received training in end of life care and were supported by the Local Hospice team. The service worked well with allied health professionals.

A number of audits had been developed, including those for accidents and incidents, care plans, medicines and health and safety. Maintenance records for equipment and the environment were up to date, such as fire safety equipment and hoists. Staff said they were encouraged to suggest improvements to the service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

Richmond remains Require Improvement.

People's safety was put at risk because some people's care plans and risk assessments were not up to date and had not reflected important changes to people's health and well-being.

There were systems to make sure risks were assessed and measures put in place where possible to reduce or eliminate risks. However, staff were not following their organisational medicine administration policy and there were some areas of 'as required' medicines that needed to be improved. Medicines were stored safely.

There were sufficient staff to meet people's individual needs. Comprehensive staff recruitment procedures were followed

Staff had received training on safeguarding adults and were confident they could recognise abuse and knew how to report it. Visitors were confident their loved ones were safe and supported by the staff.

Is the service effective?

Good

Richmond remained Good.

People were supported to maintain good health and were supported to access health professionals.

Staff received regular training, supervisions and an annual appraisal.

People were supported to eat and drink to maintain their health and well-being.

People's rights were protected by staff who had received training and had knowledge of the Mental Capacity Act 2005.

Is the service caring?

Good

Richmond remains Good.

People were supported by staff who were kind, caring and supported their independence.

People were involved in decisions about their care and the home.

People's privacy and dignity was respected and maintained.

Is the service responsive?

Good

Richmond remains Good.

People's preferences and choices were respected and support was planned and delivered with these in mind.

Group and individual activities were decided by people living in the home and regularly reviewed by them.

A complaints procedure was in place. People and visitors knew how to raise a concern or make a complaint but also said they had no reason to.

Is the service well-led?

Requires Improvement

Richmond was not consistently well led.

Quality assurance systems needed to be further developed and embedded into everyday practice to ensure people received consistent good care.

The registered manager, staff and provider encouraged people, their relatives and friends to be involved in developing the service.

The service worked in partnership with other relevant organisations.

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 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.

We inspected the service on the 08 and 09 November 2018. This was an unannounced inspection. The inspection was undertaken by two inspectors and two experts by experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We reviewed the information we held about the home, including previous inspection reports and the Provider Information Return (PIR). This is a form in which we ask the provider to give some key information about the service, what the service does well and improvements they plan to make. We also looked at the action plan provided following our last inspection. We contacted the local authority to obtain their views about the care provided. We considered the information which had been shared with us by the local authority and other people, looked at safeguarding alerts which had been made and notifications which had been submitted. A notification is information about important events which the provider is required to tell us about by law.

During the inspection we reviewed the records at the home. These included staff files which contained staff recruitment, training and supervision records. Also, medicine records, complaints, accidents and incidents, quality audits and policies and procedures along with information in regards to the upkeep of the premises.

We looked at six care plans and risk assessments along with other relevant documentation to support our findings. We also 'pathway tracked' six people living at the home. This is when we looked at their care documentation in depth and how they obtained their care and treatment at the home. It is an important part of our inspection, as it allowed us to capture information about a sample of people receiving care.

During the inspection we spoke and met with 20 people and five relatives to seek their views and experiences of the services provided at the home. We also spoke with the manager, provider, seven care staff and two members of ancillary staff. During the inspection process we spoke to health and social care

professionals that worked alongside the service to gain their views.

We looked at areas of the building, including people's bedrooms, the kitchen, bathrooms, and communal areas. 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) during lunchtime. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We also used communication aids that people themselves used, to communicate with them. We observed the care which was delivered in communal areas and spent time sitting and observing people in areas throughout the home and were able to see the interaction between people and staff. This helped us understand the experience of people who could not talk with us.

Requires Improvement

Is the service safe?

Our findings

At our inspection in September 2017 this key question was rated Requires Improvement because improvements were needed in the management of 'as required' medicines. This inspection found that it remains Requires Improvement because improvements were needed to medicine giving processes and peoples risk assessments were not always completed consistently.

People told us they felt safe living at Richmond. One person told us, "I feel safe." Another person told us, "I like it here." Visiting relatives also confirmed they felt confident leaving their loved one in the hands of staff at Richmond." However, we found that people's safety was put at risk because some people's care plans and risk assessments were not up to date and did not reflect important changes to people's health and well-being.

People's care plans contained risk assessments for a range of daily living needs such as falls, nutrition, skin pressure areas. However, not all risk assessments had been reviewed accurately and updated to ensure they reflected people's current needs and associated risks. For example, one persons' Waterlow score tool (Waterlow score tool gives an estimated risk for the development of a pressure sore) was incorrect. The risk assessment, skin integrity care plan and body map did not reflect a moisture lesion mentioned in the wound care plan or whether it had healed or was still being treated by the district nurses. There was no risk assessment or mention of the pressure relieving mattress (used to prevent pressure ulcers) and the setting it should be on. Pressure relieving mattresses need to be set in line with people's individual weights and according to the manufacturer's instructions or they can further increase people's risk. When checked it was incorrect which could have put the person at an additional risk. The person also used an air cushion when sitting in a chair and there was no record of the setting it should be on or if it was regularly checked. These issues were brought to the management team's attention and immediately dealt with to mitigate risk.

To judge the impact of these shortfalls we talked to staff who were able to tell us confidently how they supported the person. To maintain proportionality, we also viewed six other people's care plans and found them reflective of the peoples care needs. We have commented on this in more detail in the well-led question.

Staff who gave people their medicines were not following The National Institute for Health and Care Excellence (NICE) good practice guidance or their organisational dispensing policy and procedure. Staff did not use the trolley or take the medicine administration record (MAR) with them to each person. Staff dispensed the medicines into pots before asking people if they were ready for their medicines and this meant the medicines were then destroyed not giving people the opportunity to take their medicines later. This meant that people did not always get their prescribed medicines.

As required medicines (PRN) whilst having a good protocol in place, were according to their MAR offered every four hours or more frequently and documented as not given or signed as given. This included a mood-altering medicine which according to the people's individual protocol should only be given or offered when agitated. PRN records for the use of mood altering medicines and pain killers did not evidence the reason for

giving the mood- altering medicine regularly and had not been evaluated for their effectiveness or benefit. Therefore this could have put people at risk of receiving unnecessary medication.

We recommend that the service consider current guidance on giving medicines and of giving PRN medicines to people alongside their prescribed medication and take action to update their practice accordingly.

There were appropriate arrangements for the safe management of medicines. The provider's medicines management policy covered all other key areas of safe and effective medicines management. Medicines were stored appropriately and temperature checks for treatment rooms and clinical refrigerators were recorded on a daily basis. People's MARs showed the medicines a person had been prescribed and recorded whether they had been administered or the reasons for non-administration. Overall the records we viewed were up to date with no omissions. Staff who administered medicines were trained and were required to undertake an annual competence assessment. Medicine audits were up to date.

As far as possible, people were protected from the risk of abuse or harm. Staff had received safeguarding training, they demonstrated an understanding of different types of abuse and described what action they would take if they had any concerns. Staff had read the whistleblowing policy; they stated they would report any concerns to senior staff on duty and the registered manager and they were confident their concerns would be dealt with. Staff were also aware they could inform the local authority or CQC and the contact details for the relevant bodies were available in the office. People, relatives and staff said they had not seen anything they were concerned about. Relatives told us of resident and family meetings and said an open door policy enabled them to raise any concerns with the registered manager or senior staff at any time.

The home was clean and well maintained, there were regular audits to make sure cleanliness levels were maintained. People told us, "No complaints." Staff made sure infection prevention and control was considered when supporting people with their specific care needs, such as continence care, and used the relevant personal protective equipment (PPE) such as gloves or aprons when needed.

Risks associated with the safety of the environment and equipment were identified and managed appropriately. Regular fire alarm checks had been recorded, and staff knew what action to take in the event of a fire. Health and safety checks had been undertaken to ensure safe management of utilities, food hygiene, hazardous substances, moving and handling equipment, staff safety and welfare. There were good systems to ensure moving and handling equipment was serviced, checked and maintained to a safe standard. These included checks on the hoists and slings, weighing scales, wheelchair maintenance and the lift. There were monthly checks of the nurse call system and window restrictors. Water temperatures had been tested weekly and portable appliances annually. Checks were also carried out in relation to gas and electrical servicing and legionella. There was a business continuity plan which instructed staff on what to do in the event of the service not being able to function normally, such as a loss of power or evacuation of the property. People's ability to evacuate the building in the event of a fire had been considered and where required each person had an individual personal emergency evacuation plan (PEEP).

Accidents and incidents were documented and recorded. We saw that accidents and incidents were responded to by updating people's risk assessments and any serious incidents were escalated to other organisations such as safeguarding teams and CQC. Staff took appropriate action following accidents and incidents to ensure people's safety and this was clearly recorded. We saw specific details and follow up actions by staff to prevent a re-occurrence was documented. Any subsequent action was shared with all staff and analysed by the management team to look for any trends or patterns. This demonstrated that learning from incidents and accidents took place.

Since the last inspection safe and robust recruitment processes had been sustained. We looked at four staff files. All had Disclosure and Barring Service check (DBS). The Disclosure and Barring Service (DBS) helps employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups. At least one reference was in place before the start date, usually two and there was evidence of chasing up references. The checklist stated one reference must be from the person's most recent employer. All had a good record of their interview with the registered manager and provider, with appropriately targeted questions relevant to the post and the needs of people in the home. All had full employment history and evidence of checks on identity. Where people had certification of in-date training from previous employers, this was accepted and recorded in the training matrix and then booked in for further training. Staff were issued with a staff handbook and The General Social Care Council (GSCC) code of practice.

There were enough staff working in the home at this time to meet people's needs. The accident and incident audits for the past year had not identified any trends that identified insufficient staffing at any certain time. People told us the staff were always available and we saw that staff responded promptly when people used their call bell for assistance. One person said, "I get help when I need it." A visitor said, "Staff are busy but they are good." Staff told us there were enough staff to provide the support people needed. One member of staff said, "It is busy but manageable." Feedback from people and our observations indicated that sufficient staff were deployed in the service to meet people's needs. Staff were available for people, they were not rushed and supported people in a calm manner. We saw staff sitting with people in communal areas and spending time with people. People also approached staff for support throughout the inspection process and were always engaged with promptly. Agency staff were used to cover shifts and the provider ensured that as much as possible they were regular staff so as to provide continuity to the people who lived at Richmond.

Good

Is the service effective?

Our findings

At our last inspection this key question was rated Good. This inspection found it remained Good.

People said the staff knew their needs well. Relatives felt people received an effective service and health and personal care needs were being met. One person said, "Very good, I get to see my doctor when I need to, staff are well trained." A visitor told us, "The staff are very well trained I think, they keep us informed of all changes."

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures 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 had the appropriate legal authority and were being met. People that could, commented they felt able to make their own decisions and those decisions were respected by staff. All of the staff had received training in the 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 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 meet 'people's 'needs, for example, dementia care and managing behaviours that challenge. There were opportunities for staff to complete further accredited training such as the Diploma in Health and Social Care. One staff member told us, "We have a really good range of training really interesting." Staff also told us that practical training, such as fire and moving and handling was arranged. We observed good practices throughout the inspection in moving people safely. However it was observed that one person became agitated during a manoeuvre, which could have been handled more efficiently by staff. We were told that this would be addressed through practical competency assessments. Medicine training and competency assessments were undertaken and staff only gave out medicines once assessed as competent.

Staff received supervision regularly. Feedback from staff and the manager confirmed they received supervision and felt supported by the management team. One staff member said, "I find supervision really

helpful as it gives me the opportunity to discuss my job and if I have any problems I can request extra supervision." 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's needs were assessed and care, treatment and support was delivered in line with current legislation and evidence-based guidance that achieved effective outcomes. People's skin integrity and their risk of developing pressure wounds had been assessed using a Waterlow Scoring Tool and a Malnutrition Universal Screening Tool (MUST). These assessments were used to identify which people were at risk of developing pressure wounds and action taken included appropriate equipment to relieve pressure to their skin, such as specialist cushions and air mattresses and fortified diet. There were some discrepancies found in the way staff used the tools and this was to be addressed by further training. This has been confirmed by the area manager and registered manager.

People's nutritional needs were met. They told us they enjoyed the food and had enough to eat and drink throughout the day. Comments included, "It's good food yes, lots of choice, normally 2 choices per meal," "Food is good, I choose depending on what we have got" and "It's good food to a certain standard, what I mean is it is good nutritious food but not that exciting."
Nutritional assessments were in place and identified if anyone was at risk of malnutrition, dehydration or required a specialised diet. Information about people's dietary requirements were in their support plans and in the kitchen, for the cook. Information for the cook was updated daily so they were aware of people's individual requirements. The catering team were knowledgeable about people's nutritional requirements and were committed to producing good, healthy and nutritious food. Food was attractively served and this included the pureed and soft meals. A choice of meals was offered and alternatives were available. Where necessary people's food and fluid intake was recorded.

Most people chose to eat their meals in the dining room/lounge area and the menu for the meal was displayed in communal areas and on tables. The tables were laid with table cloths, condiments and cutlery. People were able to sit where they wanted to and we observed people felt comfortable eating at their own pace and in their own time. This made mealtimes a sociable occasion. There was a choice of hot and cold drinks available throughout the day and fresh fruit was available. Everyone we spoke with said they enjoyed their meals. People's weight was monitored monthly and staff sought advice as required.

Staff provided care and support to people with swallowing difficulties, for example following a stroke. For people assessed with a swallowing difficulty, the use of thickened fluids when drinking was required to minimise the risk of choking and aspiration as thickened fluids are easier to swallow. Staff were responsible for the management of thickened fluids and guidance was in place on the required texture of thickened fluids. Input from dieticians and speech and language therapists were also sourced. Guidance was readily available in people's care plans about any special dietary requirements such as a soft diet. One person's care plan contained clear information in respect of their special dietary requirements which was shared with the chef and kitchen team. We saw that this person received the food they needed.

People's individual needs had been met by adaptations to the home and equipment was provided to ensure they were as independent as possible. The home was purpose built. All rooms had an ensuite facility and there were specialised baths and wet rooms for communal use. People were supported to move around the home and were assisted to remain mobile by staff. All areas of the service were accessible via a lift. Walking aids, such as walking frames were provided and staff assisted people who were unable to weight bear to transfer using either stand aid hoists or electrical hoists. The garden areas were safe and accessible to people who lived at Richmond.

Good

Is the service caring?

Our findings

At our last inspection this key question was rated Good and this inspection found it remained Good.

People were supported by staff who were both kind and caring and we observed staff treated people with patience, kindness and understanding. There was a happy and friendly atmosphere in the service. The interactions between people and staff were very positive. We heard and saw plenty of laughter and smiles. Staff were attentive to people's needs and understood when people needed reassurance, praise or guidance.

People were supported by staff who had the skills and knowledge to communicate and care for them. Staff understood how to meet people's individual needs and knew people's particular ways of communicating. Staff introduced us to people and supported us when we met and spent time with people. This showed us the staff knew people well.

People's care plans included detailed assessments of their verbal and non-verbal communication. These were used by staff to identify physical and verbal cues and to understand when someone was happy or was starting to become distressed. The assessments described the action staff needed to take to support and reassure the person. Care plans also recorded people's likes and dislikes and information was provided to staff on people's preferences. Throughout our inspection staff were observed using non-verbal as well as verbal communication to interact positively with people.

People were supported to express their views and be actively involved in making decisions about their care and support when possible. One person said, "I can talk to staff they are all very nice," and another, "I choose to stay in my room, but I expect I could join in if I wanted to."

People told us how staff supported them, for example one person said, "Staff know that I have painful legs and make sure that when I go out, I have a wheelchair so I don't miss out." Staff knew people well and what was important to them, such as how they like to spend their days. We saw that staff reminded people respectfully of events or trips so they could make their own decision. This helped to ensure people were involved in any discussions and decisions about their life choices as much as possible.

People had their privacy and dignity maintained. We observed staff knocking on people's bedroom doors to gain entry, and people were always involved and asked if they were happy for us to visit and speak with them.
Staff spoke to people respectfully and in ways they liked to be spoken to. We observed staff having fun and joking with people who all enjoyed these interactions. Everyone we saw during our inspection presented as well dressed and groomed. People wore clean clothes that were individual to them in terms of fashion and their preferred dress sense. Attention had been made to hair, teeth and nails, we observed staff assisting one person with their jewellery. Foot wear was seen as part of people's risk assessment, especially for those at risk of trips and falls. People wore well-fitting foot wear.

People's rooms reflected their individual preferences and backgrounds. Rooms were very personalised with family photographs, personal items and pieces of their furniture. Staff had begun to personalise people's doors with door knockers of their choice and memory boxes which their families could contribute to.

Staff continued to support people to maintain relationships with people who were important to them. One person spoke of visits out with family and how much that meant to them. Another person was supported to telephone their family, they told us "I have a phone in here, I speak to my brother and sister on it."
We saw compliments from families that told us that staff enabled and supported both the person and family members to keep in touch and how much this meant to them. Staff showed concern for people's wellbeing. The care people received was clearly documented and detailed. If staff noted a change or deterioration in their well-being, this had been referred to the appropriate health professional.

The registered manager and provider understood the importance of confidentiality. People's records were kept securely and only shared with others as was necessary. This was in line with their policy on General Data Protection Regulations (GDPR). Staff spoke to us about how people would be treated and cared for equally regardless of their sexual orientation, culture or religion. The management and staff said everyone would be treated as individuals, according to their needs.

Good

Is the service responsive?

Our findings

At our last inspection this key question was rated Good. This inspection found it remained Good.

Before moving into the home, a pre-admission assessment was completed to ensure people's needs and preferences could be met at Richmond. These were completed, as far as possible, with each person, and where appropriate, their representative. Information from the pre-assessment was then used to develop care plans and risk assessments. These were regularly reviewed and updated as people's needs changed. We found not all care plans were up to date and this has been addressed in the well led question as it was a recording issue and not reflective of the care delivery. Staff were updated about changes to people's care and support needs at each shift handover. A handover sheet was in place which provided staff with an overview of people's support needs, for example mobility and dietary support.

Care plans included information about people's needs in relation to personal care, mobility, pressure area risks, nutrition, health and personal preferences. People received care that was person-centred and reflected their individual choices. Staff knew people well; they had a good understanding of them as individuals and were able to tell us about people's daily routines, care and support needs, choices and interests. Staff responded to people's needs appropriately. This included support with mobility and at mealtimes. Regular position changes for people who were at risk of pressure damage and support to maintain appropriate continence. There was also specific information recorded about how each person liked to be supported and if they had any particular preferences for example, one person said, "I only like lady carers, it's in my book that I don't like men to wash me." 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.

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 support and care provided was personalised and based on people's preferences. The activity programme included regular in-house activities. There were two activity coordinators, both were enthusiastic and committed to their role. There was an entertainments board and activity planner that told people what was happening on a day to day basis. There were various facilities which included a hairdressing salon, cinema room with access to computers with wifi and a separate activity room with a table tennis table which had proved popular with people who could also use it from their wheelchair. There were tropical fish tanks in each unit and people had access to a piano. People told us that they enjoyed the shopping trolley so they could buy toiletries, sweets and biscuits. People could also buy cards for special occasions.

A number of activities were provided throughout the inspection and these varied depending on what people wanted to do. Activity co-ordinators planned activities around the needs of the residents and time of year. They were preparing for Christmas and had organised a Christmas fete, carol singers from the local school

and shopping trips. Plans were underway for organising meals out and they were going to a local Chinese restaurant with people in the near future. They also offered exercise sessions, dancing, quizzes, games, pet visits and external entertainers. We were also told of one to one visits to people in their rooms to included talking, reminiscence, nails, music and pampering. The registered manager told us the introduction of their own mini bus had really contributed to people being able to go out regularly which has improved people lifestyle.
Managers and staff worked with other healthcare professionals to ensure people could remain at the home at the end of their life and receive appropriate care and treatment. This included having 'anticipatory medicines' available, so people remained comfortable and pain free. End of life care plans were in place for people, which meant staff had the information they needed to ensure people's final wishes were respected. Where people had chosen not to engage in these conversations, with the person's permission, discussions had been held with family and those closest to them. One family told us that the staff had been so kind when their loved one became poorly, they had ensured they were comfortable, pain free and never left on their own; they were now stable. They also said the staff had looked after them as well during this time.
From 1 August 2016, all providers of NHS care and publicly-funded adult social care must follow the Accessible Information Standard (AIS) in full, in line with section 250 of the Health and Social Care Act 2012. Services must identify record, flag, share and meet people's information and communication needs. The registered manager was familiar with AIS and they had identified the communication needs of people. Communication was part of the individual assessment tool completed for each person. Any needs identified to facilitate communication were recorded and responded to. For example, one person had poor sight and staff ensured large print. Staff took account of people's hearing aids and glasses making sure they were available, clean and working. The registered manager confirmed information on the service could be made available in larger print if required. There was a problem with the printer and this had affected the print of menus and activity programme which made it hard to read clearly but this was being addressed. New signage was slowly being introduced to assist those people who lived with dementia. We were told, "We are doing it slowly so as not to overwhelm people or add to their memory loss."

People were sensitively supported to communicate in ways that were meaningful to them. For example, one person with cognitive difficulties was supported by a member of staff. The member of staff clearly understood how to communicate effectively with the person who they supported to participate in a group activity.

A complaints procedure was in place; this was readily available to people and relatives. The procedure was displayed in the reception area and given to people as part of their welcome pack when they moved into the home. We looked at the complaints file and saw that complaints managed in accordance with the provider's policy. We read the details of a recent complaint and the actions required had been checked and followed up by the registered manager. The people and relatives we spoke with had not had a reason to make a complaint, but felt confident they could do so if needed.

Requires Improvement

Is the service well-led?

Our findings

At the last inspection, this key question was judged to be Requires Improvement as time was needed to embed robust quality assurance to drive and sustain improvement. This inspection found that it remained Requires Improvement. We found improvements in some areas but they had not been consistent and the systems to assess the quality of the service provided or to monitor and mitigate risks to people were not fully implemented or embedded into practice

The manager was supported by the provider and a deputy manager. The provider and staff had worked hard over the past year to drive improvement and introduce new documentation. Staff were committed to improving the service. The provider and management team were open and transparent about the problems they had experienced with staffing and the need to use agency staff to ensure people's safety. The recruitment of staff was progressing and we met with staff who had just started work. One new staff member said, "I was made welcome and the induction is going well, I feel supported by all the staff."

The systems to assess the quality of the service or to monitor and mitigate risks to people were not fully implemented or embedded into practice. There were a range of audits and these were carried out; however these had not all been effective in bringing about improvements. The provider had not ensured all records relating to the service were accurate, complete and up to date. Risk assessments and care plans for people had not always been updated to reflect changes to their health and well-being and this had not been identified through the audit system for care plans. For example, one person's weight records identified a 6 month weight loss of 7.8kgs. This had not been cross referenced back in to the care plan or risk assessment as to how this was being managed. However, from talking with the chef and staff we found that the person's meals were being fortified. One person's risk assessment, skin integrity care plan and body map did not reflect a moisture lesion mentioned in the wound care plan or whether it had healed. Again, from talking with staff we found that it had healed. One person had been given a pressure relieving mattress as staff thought it was required, but this had not been documented or the setting checked to ensure it was set as per the manufacturer's instructions. This was immediately rectified. The registered manager informed us that five care plans were randomly audited every month, but this had not captured the shortfalls we found.

Other areas had not been identified by the provider's audits. Fluid charts were inconsistently completed and some were inaccurate and therefore not beneficial in monitoring people's fluid intake to prevent dehydration. Following the inspection, systems for monitoring fluid charts for those at risk of dehydration had been delegated to the management team. Staff were not following NICE best practice guidance and their organisational policy for giving people their medicines and whilst this had been noted, action had not been taken to risk assess their practices to ensure medicines were given safely and as prescribed. Further medicine training was immediately organised.

The above issues are areas that required improvement.

Records and documents pertaining to the running of the home which included health and safety checks were all up to date and readily available at the service. Feedback was gained from people by annual

satisfaction questionnaires and by regular resident and family meetings. We attended a residents' meeting during our inspection. The meeting was resident led and the minutes taken by one of the people who lived in Richmond. The meeting was open and transparent and people were listened to. People made suggestions, for example having a Beetledrive, which people told us was a traditional Methodist game. Some people expressed the desire for choice when it came to what music was played in communal areas. These ideas were discussed and agreed as going forward. Towards the end of the meeting, one person said to the activities coordinator, "We are very lucky to have you organising all this for us" to which cheers of, "Here Here" came from around the room. The registered manager reminded people they can invite families for Christmas lunch and they can bring visitors in for their Birthday meal. The residents meeting overall was very positive, and people felt valued and included.
Visitors and people told us that ,"Staff listened" and, "('Deputy Manager) is really nice, she does her best for us"
There was an open culture at the service. The registered manager was visible and worked at the service 9am until 5pm, five days a week. She had a good understanding of people and their individual support needs. She said, "It is always difficult taking over as manager and getting to know people and staff, but we have really worked together as a team and come a long way." The registered manager told us that they had an open door policy which had really supported the home to be able to rectify any concerns before they become bigger issues and offer support in any areas where it may be needed. A visitor said, "A really good team here, I'm very satisfied with the home." Staff told us they enjoyed working at the service and told us, "We are a team, I enjoy working here," and "Really good support, lots of training."

Falls, accidents and incidents were recorded, monitored and an action plan put in place to prevent a re-occurrence. Call bell responses were monitored to ensure staffing levels were sufficient.

The service worked in partnership with key organisations to support the care provided and worked to ensure an individual approach to care. Visiting health care professionals were positive about the way staff worked with them and this ensured advice and guidance was acted on by all staff. Comments received included, "No concerns about the care here, staff very keen to get advice and they follow our guidance" and, "Will contact us if they have concerns."

Relatives felt they were able to talk to the manager and staff at any time and the relatives' meetings provided an opportunity for them to discuss issues and concerns with other relatives, friends and management on a regular basis. One relative said," The management team were constantly looking at ways to involve people and their families in the running of the home," this included inviting them to regular meetings and inviting them to give feedback.

The health and social care professionals we contacted did not express any concerns at the time of our inspection. External health care professionals such as the GP and dietician, contacted, informed us that staff were kind and followed their guidance.

The provider was aware of the requirement to inform the Care Quality Commission of events or incidents which had occurred at the service. The commission had received appropriate notifications, which helped us to monitor the service. From April 2015 it was a legal requirement for providers to display their CQC rating. The provider was displaying their rating correctly.