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?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection at Richmond in January 2016. A breach of Regulation was found. As a result we undertook an inspection on 2 and 3 March 2017 to follow up on whether the required actions had been taken to address the identified shortfalls. At this inspection we found the previous breach had been met; however we found additional concerns and further breaches of regulation.

Richmond is located in Bexhill-on-Sea and provides accommodation and personal care for up to 58 older people requiring support with 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 50 people living at the home.

A registered manager was 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 and associated Regulations about how the service is run.

People living on the first floor of the service were not consistently responded to in a timely manner due to insufficient numbers and deployment of staff. Throughout our inspection we heard call bells ringing for extended periods; staff told us their responsiveness was impacted by the provider's high use of agency staff.

We found two occasions where the providers own safeguarding procedures had not been consistently adhered to in regard to notifying appropriate external authorities in a timely manner.

The shortfalls in the recording of PRN (as required) Medicines we found at our last inspection had continued and additional concerns were identified in the administration and disposal of medicines.

Staff told us their morale was low and that they did not always feel listened to by senior staff. We found staff knowledge and understanding in areas such as the Mental Capacity Act 2015 (MCA) and behaviours that challenge required improvement. The provider had not ensured that staff completing MCA assessments had a clear understanding of how to capture and record people's capacity in line with legislation. MCA assessments did not evidence how staff had arrived at decisions related to people's capacity via best interest meetings and discussions.

Although we saw kind and caring interactions between people and staff we also found instances when there had been shortfalls in the staff approach in regard to confidentially, dignity and respect.

The provider had not ensured people's care was consistently responsive to their support needs. Care plans did not always reflect people's individual care and support needs and were not consistently person centred. The provider's reliance on care agency for an extended period meant that the continuity of care people

received was variable. We found there were occasions during our inspection where there was a lack of provision for people in respect to social activities and interaction with staff.

Some of the established quality assurance systems had failed to provide senior staff with clear oversight of the service. Audits related to care plans and call bells had not identified the concerns we found during our inspection. Effective leadership was not evident on the floor and the issues which had impacted on low staff morale had not been addressed.

Appropriate checks had been completed when new staff were recruited to ensure they were safe and suitable to work within a care environment. There were systems and processes in place to routinely check all equipment including those related to fire safety and health and safety.

People had a choice as to where they ate and they and their relatives were positive about the food provided. People told us they felt listened to in regard to their comments and suggestions about food and mealtimes.

People and their relatives were positive about the physical environment and aspects of the care they received such as their rooms and the support they received to dress the way they chose.
The provider had established an organisational system whereby the registered manager was provided with practical support and guidance from area and regional managers along with head office support in regard to areas such as HR.

We found breaches in Regulation. 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?

Requires Improvement

Some aspects of the service were not safe.

The provider had not ensured there were sufficient numbers of staff to respond in a timely manner to people's support needs.

The providers reporting procedures for safeguarding had not been followed consistently.

We found shortfalls in the administration and disposal of medicines along with the management of 'as required' medicines.

Risks related to people's support needs and the environment had been assessed.

The provider had carried out checks on staff to ensure they were suitable and safe to work with people.

Is the service effective?

Requires Improvement

The service was not always effective.

The provider had not ensured and evidenced staff had undertaken best interest assessments in line with the best practice framework associated with the MCA.

Although a suitable training programme had been established we found staff did not consistently apply their knowledge.

Staff received regular supervision however low morale was attributed to the high use of agency staff over an extended period of time.

People enjoyed their food and meals times.

Is the service caring?

Requires Improvement

The service was not always caring.

The provider had not ensured that people were not consistently shown dignity and respect by staff.

Relatives and friends told us they were unrestricted as to when they able to visit people

Peoples care records were held securely.

Is the service responsive?

Requires Improvement

The service was not always responsive.

The activities and social programme provided did not provide consistent coverage.

The provider had not made provision to ensure all staff were able to respond to people's support needs in a timely and person centred way.

Care plans did not always provide staff with a person centred picture of their support needs.

A complaints policy was in place and was seen to respond effectively when relevant.

Is the service well-led?

Inadequate

The service was not well led

A range of systems for quality review were in place however had not always been effective and failed to identify the shortfalls we found.

The provider had failed to ensure timely actions had been taken to address the impact of high use of agency staff at the service.

Effective leadership for care staff whilst working on the floor was not always evident.

People told us they were provided with opportunities to feedback their opinions on the service.

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 2 and 3 March 2017. This was an unannounced inspection. Three inspectors and an expert by experience undertook the inspection. 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 last inspected Richmond Care Home in January 2016 where we found the service required improvement and was in Breach of one regulation.

We observed care delivery throughout our inspection. We looked in detail at care plans and examined records which related to the running of the service. We looked at eight care plans and four staff files, staff training records and quality assurance documentation to support our findings. We looked at records that related to how the home was managed. We also 'pathway tracked' people living at Richmond. This is when we look at care documentation in depth and obtain views on how people found living there. It is an important part of our inspection, as it allowed us to capture information about a sample of people receiving care. We spent time observing care and used the short observational framework for inspection (SOFI), which is a way of observing care to help us understand the experience of people who could not talk with us.

We looked at all areas of the service, including people's bedrooms, bathrooms, communal lounges and dining areas. During our inspection we spoke with twenty people who lived at the service, eight care staff, the chef, two domestic staff, two area managers, the registered manager and their deputy. We also spoke to nine people's relatives and two health care professionals who were visiting the service during our inspection.

We considered information which had been shared with us by the local authority, members of the public and relatives. We reviewed notifications of incidents and safeguarding documentation that the provider had sent us since our last inspection. A notification is information about important events which the provider is required to tell us about by law.

Requires Improvement

Is the service safe?

Our findings

At the last inspection in January 2016, the provider was in breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had failed to take appropriate security steps in relation to an external and internal door. The provider sent us an action plan stating how they would meet the requirements of the regulations by June 2016.

At this inspection we found actions had been taken to improve the security measures and the provider had met the requirements of Regulation 15. However despite these improvements, we found additional breaches in Regulations.

People told us they felt safe living at Richmond. One person said, "Yes, as safe as houses, always have done." Although we received positive feedback from people and their relatives we found aspects of the service were not consistently safe.

At our last inspection we identified concerns on the first floor of the service regarding staffing levels and response times; in particular during the afternoon when staffing levels reduced. During that inspection senior staff increased staffing numbers on the first floor during the afternoon and we found this had a positive impact on staff responsiveness. However, at this inspection we found staffing numbers had returned to the original January 2016 on the first floor. Senior staff told us this was because there had been a fall in the number of people living on the first floor. Although there were two less people living on the first floor at this inspection people's support needs had increased. All care staff told us the number of staff on the first floor was not sufficient to meet people's needs in a timely manner. Throughout our inspection we observed multiple delays in calls bells being responded to in a timely manner. We reviewed recent call bell audits and found examples of call bells left unanswered in excess of ten minutes. Staff told us the delays were a direct result of insufficient numbers of staff. One staff member said, "On this floor (first floor) we have five residents who require a hoist (mechanical lifting equipment), which needs two staff for each time a resident needs to move." They added, "It means at times in the afternoon it only leaves one staff member available as the senior can be doing medication." All staff said the high use of agency staff also slowed down their ability to respond promptly. One person said, "It's got worse, I press my button and it seems like I wait an age." A relative said, "I have noticed things seem more stretched; a lot of rushing about by staff." Another relative said, "It's as if the staff can't hear the bells, they get so used to them." We spoke to senior staff regarding our concerns and in response they moved one staff member from the ground floor to the first floor in the afternoon. Although this additional staff member was seen to alleviate staffing pressures, staff on the ground floor said this impacted on their ability to spend time chatting with people. Senior staff acknowledged there were issues which were either related to deployment or staffing numbers and committed to undertake a review.

The concerns related to the number of staff available to support people are a breach of the Health and Social Care Act 2008 Regulation 18 (Regulated Activities) Regulations 2014.

At our last inspection we found areas required improvement in regards to PRN 'as required' medicines. At

this inspection we found these issues remained and additional concerns were also identified. There were shortfalls in the administration and disposal of medicines. Some people were at risk of not receiving PRN medicine as they required it, such as pain relief due, to lack of guidance and risk assessments. PRN guidance within people's care documentation did not consistently provide appropriate detail and guidance for staff. PRN medicines should only be offered when symptoms are exhibited; such as pain relief medication. PRN pain relief should have a corresponding pain chart so staff have the information on how effective the pain relief medication was and whether the GP should be informed to consider whether a different approach should be taken. Staff had not recorded the reason for a person refusing their medicines; this person had refused their prescribed medicines for four days, there was no evidence their GP had been informed or that the staff had reflected on what may happen to the person's health and well-being as they had not taken their medicines.

On both days of our inspection we saw that some people's morning medicines prescribed to be given at 8am took up to three hours to dispense. The midday medicines were dispensed at midday. Staff could not be assured that medicines prescribed to be given four hourly apart had this gap. This is not in line with The National Institute for Health and Care Excellence (NICE) good practice guidelines and does not ensure that people received their medicine on time or safely.

We identified a discrepancy with one person's 'just in case medicines.' These are medicines which are anticipatory and prescribed 'just in case' you need them to help relieve pain or other symptoms if needed. The wrong person's 'just in case' medicines had been returned; this meant that the controlled medicine records were incorrect. This meant that if the person required these "just in case" medicines they would not have been available. Senior staff took immediate action to correct this once identified by the inspector.

We saw poor practice in regard to infection control principles. A staff member was seen carrying soiled laundry in their arms without a barrier between their uniform and the laundry. This meant this staff member's uniform presented an increased risk of cross infection should they support a person. We found examples of continence equipment with dark stains which would indicate effective and appropriate cleaning had not been routinely completed.

The identified concerns related to people's medicines and infection control are a breach of the Health and Social Care Act 2008 Regulation 12 (Regulated Activities) Regulations 2014.

However we found some aspects of the management of medicines was safe. For example, the medicine room was locked and medicine trolley was secured when not in use. The temperature of areas where medicines were stored were routinely checked to ensure medicines were not harmed before use. The medicine fridge was clean and the temperatures recorded daily. Staff were vigilant in locking the trolley when they were talking or giving medicines to people. We observed medicines being given safely and staff followed best practice guidelines. For example medicines were administered individually using pots to dispense, waiting for the medicine to be taken and then recorded on the MAR chart. All medicines were administered by staff that had completed training and had undergone regular competency assessments. MAR charts contained a recent photograph and contained information such as known allergies and how the person liked to take their medicines.

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.

Routine health and safety checks were undertaken covering areas associated with fire safety, health and

safety and servicing. Outcomes from these were recorded clearly. Maintenance and servicing of equipment such as the fire alarm and boiler were seen to be regularly completed. Staff were clear on how to raise issues regarding maintenance. One member of staff told us, "We are lucky the maintenance guys are very good."

The service had contingency plans in the event of an emergency evacuation. The service had an 'emergency grab bag' available which contained information such as a copy of people's key contact numbers and copies of people's medicine requirements. Staff and records indicated that training and testing was undertaking regularly. The provider had an agreement in place with a local church should the need arise to evacuate people from the building. All staff were trained in first aid and resuscitation techniques.

Records demonstrated staff were recruited in line with safe practice. For example, records of responses to interview questions, employment histories had been checked, suitable references obtained and all staff had undertaken Disclosure and Barring Service checks (DBS). The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services.

Requires Improvement

Is the service effective?

Our findings

At our last inspection we found the provider had not consistently provided effective care and support and identified areas that required improvement. At this inspection although we found improvements in people's meal time experience we also found additional areas that required improvement.

The CQC is required by law to monitor how providers operate in accordance with the Mental Capacity Act (MCA) 2005. The MCA requires that assessment of people's capacity should be decision specific and record how the decision of capacity was reached. Although most people's care documentation contained MCA assessments these provided limited detail and in one case identified significant shortfalls in staff knowledge and understanding in this area. We saw examples where capacity assessments had highlighted people lacked capacity based on two short questions. The outcome of these assessments recorded that these people lacked capacity for 'activities of daily life'. This is not decision specific and there was no evidence any best interests discussions had occurred to support these assessments. We spoke to a senior member of staff regarding this and they acknowledged these assessments had failed to guide staff in how they should obtain agreement to care and treatment.

We reviewed the outcome of a recent complaint made by a relative. The complaint was centred on a member of staff, who had a pastoral role, discussing future potential options with a person which were not line with their assessed needs or their advocate's wishes. Senior staff's findings from their investigation were that the staff member should not have discussed these matters and had a limited understanding of the MCA and advocacy. This staff member had not undertaken any training in the MCA. We discussed this with senior staff who acknowledged this staff member should complete MCA awareness training.

The shortfalls in staff understanding of the MCA are a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

However people told us and we observed staff seeking people's consent before care delivery. For example we heard staff ask a person, "Who you like to take your medicines now." The CQC is required by law to monitor the operation of DoLS. Staff could explain to us the implications of Deprivation of Liberty Safeguards (DoLS) for the people they were supporting. DoLS forms part of the MCA. The purpose of DoLS is to ensure that someone, in this case living in a care home, is only deprived of their liberty in a safe and appropriate way. This is done when it is in the best interests of the person, has been agreed by appropriate advocates and professionals and there is no other way to safely care for them. Where a DoLS authorisation was in place we saw the directives issued by the authorising body were adhered to.

Staff told us the company used by the provider to enable them to complete training had recently changed. Staff were positive about the new training and one staff member said it had been a 'helpful improvement'. However we found staff did not consistently demonstrate they had the skills and knowledge to support people's needs in regard to behaviours that challenge. We observed staff manage an incident where two people had displayed behaviours that challenge. Staff did not support one of the people in line with their support plan or good practice. We reviewed the most recent training data and it evidenced that less than

50% of staff had completed assigned training in this topic. A recent quality assurance audit by an area manager had identified this as an area which required improvement however timely corrective action had not been taken.

Despite staff having regular supervision we found staff did not feel always supported in their roles. One staff member said, "It has been a real struggle, we have such high numbers of agency staff that things are difficult." Another staff member said, "I have thought about leaving many times recently, we are told things will improve when we recruit more staff but it's been so slow." A further member of staff said, "I do my best but there isn't enough time, I have started to come in on my days off to catch up with paperwork." The most recent staff meeting minutes reflected that there had been continuing 'negativity' amongst staff; however there was no evidence that this meeting had been used as a forum for staff to raise their concerns. One member of staff told us, "You are just talked at in meetings and don't get the chance to get our side across." The above areas related to supporting staff and staff knowledge requires improvement.

People were complimentary about the food and meal times at the home. Everyone told us, they had enough to eat and drink. People had a choice as to where they ate their meals. One person told us, "I love having my eggs in the morning, can't beat it." Most people chose to eat in the dining rooms located on each floor. Food preparation was undertaken in the home's large ground floor kitchen and brought out to the dining areas in heated catering trolleys. A member of the catering staff plated up meals and supported care staff to serve people at neatly laid up tables. The registered manager told us the main meal was served in the evening. They said, "Using feedback from residents and staff we switched the main meal to the evening as there can be a big gap between evening and breakfast, it has been a success." The chef held regular meetings with people to collect feedback on the food and dining experience. They told us these meetings were a useful way of gaining feedback and they clearly identified the corrective actions they would take as a result of the comments received.

People had been referred to and had involvement with a range of health care professionals, these included community psychiatric nurses, continence nurses and chiropodists. One person said, "I can see my Doctor when I need to, the staff see to that for me." Relatives felt staff were effective in responding to people's changing health needs. One visiting relative said, "The staff have been good with my mum, they are very quick to pick up if there is a change in health or a problem." We spoke with one visiting health care professional during the Inspection. They were positive about the home and the staffs' approach to feedback. They said, "Staff are welcoming and take on the feedback I have given in the past." People were supported to be weighed regularly and staff told us they used this information as one indicator of people's health. Where concerns had been identified regarding people's food intake people's food intake was monitored and recorded more closely. One staff member said, "We write down everything residents eat and drink if there are worries about their weight."

Requires Improvement

Is the service caring?

Our findings

At our last inspection we found the service was not always caring and required improvement in areas related to confidentiality and dignity. At this inspection the previous concerns we identified with confidentiality had improved; however there remained issues with protecting people's dignity.

At our last inspection we found communal bathrooms on the first floor contained items which did not promote people's dignity. At this inspection we found there had been no improvement in this area and again found examples which lacked sensitivity to communal living. Examples included signage for staff regarding continence protocols and people's underwear in a communal bathroom. We spoke to senior staff regarding this issue and they told us they had removed these items at a later point in the day. They committed to again address these matters of dignity via staff meetings and supervision. We found other examples of people's dignity not being protected such as language used within a person's care plan where it stated, 'can become rude and aggressive'. A staff member was seen requesting a person to open their mouth so as the staff member could check their mouth. However this was undertaken in a communal area and did not protect this person's dignity.

In addition to the above we observed a brief incident where a disagreement between two staff resulted in them raising their voices at each other in front of a person. The disagreement was in relation to work allocation. The person involved was unable to communicate their view on the incident and as such it was not possible to determine the impact of this on them. The above issues related to dignity and respect require improvement.

We also observed caring and kind exchanges between people and staff. We heard many positive comments from people and their relatives about the staff approach. One person said, "They are very busy but they often make tricky jobs easy for me, which I appreciate." Another person said, "They are mostly very kind people, good hearts and some like a laugh and a joke, which is nice." A relative told us, "I have always been pleased with what I have seen, the staff are friendly." Permanent staff were knowledgeable about people's personalities and how they liked to receive support. We saw examples of staff working at people's own pace and not rushing them whilst supporting them. Staff were seen chatting and we saw light hearted interactions with people whilst providing support. One person's relative said, "I know my mum is not easy at times but staff stay bright and cheery."

People looked comfortable and were supported to maintain their personal and physical appearance. We heard people talking about the jewellery they were wearing. We saw examples where people had been supported to dress smartly in line with their recorded preferences. One person's relative said about a person, "They have always been up early and liked to look smart so it's nice that's continued." We overheard a staff member complementing a person on their hair after they had visited the hairdresser.

People told us they spent their day as they chose. One person told us they liked their own company, another told us they liked to read the newspaper, two people told us they liked to spend time in the lounge with other people. We observed friendship groups had developed between people and they were supported by

staff to maintain these. Throughout the inspection visitors were welcomed at the home. One visitor told us they were able to visit whenever they chose and were always made to feel welcome.

Bedrooms were personalised with people's own belongings including furniture, photographs and ornaments. One person said, "I do like my room, nice size and light and airy." People were able to spend time in private in their rooms as they chose. Bedroom doors were kept closed when people received support from staff and we observed staff knocked at doors before entering. A person told us, "They (the staff) knock on my door before they come in even if I've pressed my call bell."

People told us they were able to spend their day as they chose. One person told us they liked their own company, another told us they liked to spend time completing word puzzles and reading, another person told us they liked to go out when they felt strong enough and others told us they liked to spend time in the lounge with other people. We observed friendship groups had developed between people and they were supported by staff to maintain these. Throughout the inspection visitors were welcomed at the home. One visitor told us they were able to visit whenever they chose and were always made to feel welcome.

One person said, "I know I have got a care file, I know roughly what is in it but I'm not too bothered about detail, but I could if I wanted to." Care records were stored securely. Both paper and electronic confidential information related to people's care was kept secure.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection we found the care provided was not consistently responsive and identified areas which required improvement in regard to meaningful social interaction for people. At this inspection we again found concerns with this issue and additional areas which required improvement.

Staff and records confirmed that for the previous five months it had been necessary for the provider to use agency care staff to cover shifts due to staff sickness and staff vacancies. We spoke with agency care staff; some knew people well and had worked at the service on multiple occasions however others had not worked at the service before or for an extended period of time. People told us they had mixed experiences of care from staff supplied by agency care staff. One person said, "They're not too bad but I can't always understand them that well." Another person said, "I don't like seeing new faces all the time, it is better when our usual girls are on, they know my silly ways." We saw agency care staff routinely answering call bells. We asked two agency care staff how they knew people's support needs if people were unable to verbally communicate. They told us at the beginning of their shift they were given a list of people's names at 'staff handover' and wrote short notes on what was discussed during this meeting. This meant they had limited knowledge on people's core support needs; such as moving and handling, continence and behaviours. One agency member of staff said, "If I answer a call bell and I'm not sure what the resident needs I go and get another (permanent) staff." We saw this happen on multiple occasions during our inspection and on each occasion there was a delay in the person receiving the care they needed. Following our inspection senior staff committed, via an action plan, to introduce an abridged 'care needs' document with condensed versions of people's care plans identifying key support needs.

Care plans did not reflect people's individual care and support needs and were not consistently person centred. We found examples where people's support needs had not been recorded for staff guidance. From speaking to one person, reviewing their care plan and talking to staff it was evident the person had a complex history of mental health support needs which included depression. However their 'mental health' care plan was blank and did not provide guidance for staff on how to support them. Another person's care plan advised staff if they displayed anxiety they should be supported to move to a communal area, however on the first day of our inspection they displayed anxiety most of the day and yet remained in their room all day. Staff were unable to offer an explanation as to why the guidance in their support plan had not been followed.

At our last inspection we identified there were occasions when people were left for extended periods with limited interaction from staff. We found there was one staff member whose role was dedicated to activities and their duties were spilt between two floors. As a result of our feedback the provider increased the number of staff who were responsible for facilitating activities. Staff told us this had worked well for a period of time however these staff had now left the home. At this inspection there was one activities coordinator in post, and they worked 21 hours a week. On the first day of our inspection this staff member was not working and on the first floor we again saw people left for extended periods in lounges and rooms with limited interaction from staff.

The shortfalls we identified in providing person centre care are a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke to senior staff regarding the lack of provision for social engagement which we saw on the first day of our inspection. They explained an additional staff member had been recruited and was awaiting a start date. We also saw people enjoying positive interactions in small and large group activities. On the second day of our inspection a musical performer entertained a large group of people. One person said, "Really lovely, great fun." A person's relative said, "Music is a big hit, it can bring back lots of memories." Other regular external bookings included 'pet therapy' and musical entertainers. The activities coordinator was working on the second day of our inspection and supported one person out for some shopping and a coffee. The person told us they had a, 'a really nice time'. The home was affiliated with a nearby Church and the minister was contracted to be at Richmond for 15 hours a week. On the second day of our inspection they were seen chatting to people in communal areas and private rooms. People told us they liked the home's close connection with the Church and people's involvement in church events in the home was popular.

We received mixed feedback from people and their relatives regarding their involvement in the design of their care plans. One relative told us they knew of a care plan and had contributed to it. Another relative said, "No, it would be nice to have a bit more input." One person said, "I have been asked and feel involved." Before moving into the home a senior member of staff carried out an assessment of support needs. We looked at a completed pre admission assessment and noted information had been gathered from a variety of sources including healthcare professionals. Daily records also provided detailed information for each person and staff could see how people were feeling and what they had eaten and drunk. Most care plans contained 'life stories' which captured information on people's background, interests and likes and dislikes.

There was a complaints policy available to people within the home. During our inspection we saw this located in various points around the service. One person told us they would speak to 'any staff' if they were not happy but would talk to the manager if it was important. Complaints received had been responded to in a timely manner, in line with the provider's policy, and the complainants were satisfied with the response and the complaints closed.

Inadequate

Is the service well-led?

Our findings

At our last inspection we found the service was not consistently well led and identified areas which required improvement in regard to records and quality assurance. At this inspection we found both of these areas required further improvement. .

We found the provider's own safeguarding policy in regard to reporting allegations of abuse had not been followed. We found two examples of safeguarding allegations which had not been reported to the local authority in a timely manner. Providers have a legal obligation to report allegations of abuse so as appropriate and timely investigations can be undertaken by the appropriate authority. Senior staff took immediate corrective actions once these shortfalls had been identified.

The concerns related to safeguarding are a breach of the Health and Social Care Act 2008 Regulation 13 (Regulated Activities) Regulations 2014.

The registered manager at Richmond had been registered with the CQC since January 2017; and had been the acting manager since September 2016. We found examples where the registered manager had failed to follow the providers own internal protocols in regard to reporting accidents and incidents. For example an incident had occurred at the service five days before our inspection. The area manager told us this incident met the threshold for an internal report to be completed, referred to as a 'time critical report'; however this had not been done. The incident was also required to be reported to the Local Authority and the CQC however neither had been completed until prompted by the inspector.

We found short falls in the effectiveness of two audits. Recent call bell audits from January 2017 identified there had been repeated occasions when calls bells had not been responded to in a timely manner. Some of the sampled responses times indicated call bells had been left unanswered for up to 25 minutes. The action plan for these findings was to 'remind staff to answer call bells.' The area manager and provider's policy indicated that any call bell that rang over four minutes required an individual follow up to determine the reason for the delay. This had not occurred. The care plan audit for January 2017 sampled eight care plans at random. We found multiple actions had been identified by the senior member of staff for several of these care plans, a deadline had been set for these corrections for 21 January 2017. However none of the actions had been revisited or completed at the time of our inspection. There was no evidence any care plan audits had been completed for February 2017.

Staff told us morale in the service was low. The main reason staff attributed this to was the extended period of time high numbers of agency staff had been used at the service. One staff member said, "It has been really hard, you constantly feel like you are 'carrying' the agency staff." Another staff member said, "The morale is pretty bad, some staff are seen as favourites and work is not shared out fairly." Senior staff told us that for the previous five months, agency staff were covering up to 400 care hours a week. The registered manager told us the delay in recruitment had been complex with multiple factors at work such as poor response to recruitment advertisement. The area manager who visited the service regularly had been 'disappointed' by the length of time it had taken to fill vacancies. At the time of our inspection several new staff were awaiting

their DBS checks before starting and two new staff were shadowing more experienced staff. The registered manager said, "It has been slow going but there are new staff scheduled to start very soon."

Strong and effective leadership was not evident whilst staff worked on the floor. For example on the first floor delivering the morning medicines took three hours. Senior staff had failed to identify and take steps to address the shortfalls in the length of time it took for staff to complete medicines. Whilst senior staff were supporting people with their medicines other staff told us they did not like to disturb them as they were busy. This left staff with limited effective leadership. The impact of this was witnessed by ineffectual use of staff resources. For example a new member of staff who was completing their 'shadowing' was seen to be shadowing an agency staff member who was new to the floor. Staff were reactive and task focused and the stressors and frustrations were evident when two staff became agitated with each other regarding work allocation and raised their voices at each other. One staff member said, "The call bells don't stop and you don't feel like you are getting anywhere." A senior staff member said, "Care plans have fallen behind, it is just too busy to get these done, I have raised this with the manager."

The provider outsourced their satisfaction surveys to a third party. The area manager told us there was a delay in receiving the data back as it was not released until all services in the provider's portfolio had been collated. This meant the most recent resident feedback information via this method was from 2015. We identified a comment within the anonymised feedback where a person had raised an allegation of theft. The current registered manager was unaware of the incident as it had not been logged as a complaint. Due to the time delay senior staff were unable to historically trace which person had made the allegations. The area manager acknowledged that the current process was not effective at feeding back specific concerns raised via the survey to the home to action in a timely manner.

The above issues and the concerns identified through the inspection directly relate to the service's leadership and governance and are a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us resident meetings took place where they could discuss issues related to their lives at Richmond. The most recent meeting was well attended and a range of agenda items were discussed such as food and activities. One person said, "You get to have your say if there is something you want to get off your chest."

The registered manager told us the transition to becoming the 'home manager' had been 'challenging'; they apportioned several staffing issues and the high use of agency staff as being a contributory factor to this. The registered manager was supported by an area manager and a regional quality business manager along with a 'head office' function which provided HR and payroll support. Records indicated the area manager had visited the service regularly whilst the registered manager was new in their role. The area manager said, "We respond to and use our resources where we identify, through our audits, that a home requires additional support." Many of the issues we found during our inspection were already apparent to the area manager and they demonstrated and offered assurances on how they intended to manage the identified shortfalls. We received an interim action plan within 24 hours of completing our inspection which identified the actions already completed or planned to address the shortfalls we identified.

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	Regulation 9 HSCA RA Regulations 2014 Person-centred care The registered provider had failed to ensure peoples care was met and reflected their preferences. Regulation 9(1)(b)(c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had not taken appropriate steps to ensure people who lacked capacity were supported in line with the Mental Capacity Act (MCA) 2005. Regulation 11(1)(3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered provider had not protected people against the risks associated with the unsafe use and management of medicines. The registered provider had not assured the risks associated with poor infection control had been minimised. Regulation 12(2)(g)(h)

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The registered provider had not ensured there were systems and processes set up to effectively report potential abuse. Regulation 13 (2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered provider did not have an effective system to regularly assess and monitor the quality of service that people receive. Regulation 17(2)(a)(b)(c)(e)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The registered provider had not ensured there was sufficient numbers of suitably qualified, skilled and experienced staff deployed in order to ensure people's safety and welfare. Regulation 18(1)