Colleycare Limited

# Ryeview Manor Care Home

## Inspection report

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## Ratings

| | |
|---|---|
| Overall rating for this service | Requires Improvement |

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

# Summary of findings

## Overall summary

This inspection took place on 27 November and 4 December 2018 and was unannounced.

Ryeview Manor Care Home is a care home service. People in care homes receive accommodation and personal care as a single package under one contractual agreement. The Care Quality Commission regulates both the premises and the care provided. Both were looked at during this inspection.

Ryeview Manor Care Home provides care for up to 94 people, some of whom were living with dementia. At the time of the inspection, 91 people were living at the service.

The service had 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 2008 and associated regulations about how the service is run.

Ryeview Manor Care Home is a three-storey building set in secure grounds in High Wycombe. The home comprised four units. Three for people living with dementia in need of residential care and one specialised residential unit for people with increasing needs, living with advancing dementia. Each unit had a sitting area and dining area. There was a secure garden with seating which was accessible to people living in the service.

The service was last inspected in August 2016 and was rated 'Good' in all key questions. At this inspection we found the service no longer met the criteria for Good in caring, responsive and well led and was rated 'Requires improvement'.

Most staff interacted with people in a caring and sensitive way. We did however, observe that at times people were left seated in communal areas with little stimulation for periods of time.

Staff supported people to communicate their needs and protected their privacy, dignity and independence.

The registered manager used systems and processes to monitor quality and safety in the service, however, these were not always effective. Audits of medicines management contained insufficient detail to show all actions taken to mitigate risks and correct errors.

The provider had robust systems and processes in place to protect people from harm and abuse. Staff had completed safeguarding training and were knowledgeable about actions to take if they suspected abuse.

The registered manager deployed sufficient numbers of staff to meet people's needs and keep them safe. They used safe recruitment processes to ensure only staff who were suitable to work in a care setting were employed.

Safe systems were in place for the management of medicines and people were protected from the risk of acquiring an infection. Staff reflected on incidents to maintain people's safety and prevent reoccurrences.

People received care from skilled, knowledgeable staff who had been appropriately trained. Staff were supported with regular supervision to help develop their knowledge.

Staff were aware of the legal protections in place to protect people who lacked mental capacity to make decisions about their care and support.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

People were supported to maintain a balanced diet. Risk assessments were in place for those at risk of malnutrition and dehydration. Staff supported people to access care from appropriate health care professionals.

Care plans contained details about the type of care and support people required. There was however, insufficient evidence to show these had been written in partnership with people and their families where appropriate. In addition, some language used by some staff to describe people and their behaviours was not person-centred.

Care plans showed that some details had been recorded regarding end of life care for people. There was however, a lack of sufficiently detailed evidence to show staff had explored and recorded people's needs and preferences for the care they wished to receive in their last days.

There was a complaints policy in place and evidence showed complaints were investigated promptly and thoroughly.

The registered manager and staff were committed to delivering individualised care for people.

The registered manager used different methods to involve people, their families and staff in the service provided. Staff had linked with a local children's nursery who visited the home regularly and staff held a monthly dementia café for people and their families.

The provider maintained a contemporaneous log of accidents and incidents and reflected on these, as well as on care provided as a means of making improvements and of preventing further incidents. The deputy manager was engaged in a safeguarding project and worked in partnership with people, relatives and social services to maintain people's safety.

We found three breaches of the Health and Social Care Act 2008 (Regulated Activities) 2014. You can see what action we told the provider to take at the back of the full version of the report.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

**Good**

The service remains safe.

### Is the service effective?

**Good**

The service remains effective.

### Is the service caring?

**Requires Improvement**

The service no longer meets the criteria for good and is now requires improvement.

Most staff had caring interactions with people, however, at times staff did not respond to people showing signs of distress.

Staff supported people and their families to express their views about care provided.

Staff supported most people's privacy, dignity and independence. However, at times people's dignity was not upheld.

### Is the service responsive?

**Requires Improvement**

The service no longer meets the criteria for good and is now requires improvement.

Staff provided care which met most people's needs, however, at times staff did not respond to people showing signs of distress promptly.

Staff supported people to express their concerns. People knew how to complain. There was however, insufficient evidence to show people had been involved in planning their care.

Staff had recorded some information about care people wished to receive at the end of their lives, however there was a lack of detail about the type or care and treatment people preferred and needed. Language used to describe some people's behaviours was very negative.

### Is the service well-led?

**Requires Improvement**

The service no longer meets the criteria for good and is now requires improvement.

Staff were committed to providing individualised care for people.

Systems in place for monitoring quality and safety within the service were not always effective.

The provider involved people, relatives and staff in decisions about the service.

Staff reflected on practice to improve care for people and keep them safe.

The provider worked effectively in partnership with healthcare professionals to meet people's needs.

# Ryeview Manor Care Home

**Detailed findings**

## Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on 27 November 2018 and 4 December 2018 and was unannounced. The inspection team comprised 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. Both experts had experience of caring for older people who use services.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the information included in the PIR along with information we held about the service, for example, statutory notifications. A notification is information about important events, which the provider is required to tell us about by law.

We reviewed records which included 11 people's care plans and seven staff recruitment and supervision records. We also looked at records relating to the management of the service such as the registered manager's development plan, quality assurance audits, resident meeting minutes, staff rotas, the safeguarding project records, medicines audits and records relating to health and safety in the service. After the inspection we reviewed further evidence sent to us by the provider which included records of staff competency observations, the provider's statement of purpose and the staff training matrix. We spoke with the registered manager, deputy manager, assistant manager, five members of care staff, the head chef and second chef, two people's relatives and 24 people living in the home. We also observed people receiving care and support in communal areas.

Good

# Is the service safe?

## Our findings

People we spoke with told us they felt safe. One person said, "I feel safe. There's always someone there if I need them." Another person told us, "They look after me."

People were protected from the risk of harm and abuse by staff who had completed the required training. This was updated yearly. Staff identified types of abuse and described actions they would take if they suspected or observed abuse. Staff knew how to use the provider's whistleblowing policy to escalate concerns. The deputy manager was engaged in a safeguarding project to assess knowledge of safeguarding in people and staff. This provided learning opportunities to staff so they were well informed about signs of abuse or harm, which helped keep people safe.

Staff investigated and resolved safeguarding concerns promptly. This was confirmed by the deputy manager. They said, "We've learned. Nothing has come from any safeguarding [concerns], they've been closed quite quickly."

People's care and support plans contained appropriate risk assessments to support their safety, including the prevention of pressure ulcers and the use of safety equipment to help people move. These were reviewed and updated regularly, which helped maintain people's safety and independence.

The registered manager ensured there were sufficient staff to support people and keep them safe. This was confirmed by rotas we reviewed. The provider had the necessary recruitment procedures in place to ensure staff employed were suitable to work in a care setting. Staff recruitment files contained appropriate checks such as a criminal record check and references from previous employers.

The provider used systems and processes to manage people's medicines. Medicines administration records were completed accurately and regular audits were completed to measure quality and safety. Where people required 'as and when' medicines, the provider had policies in place for this which had been signed by the person's doctor. People's care plans contained all necessary safety information related to people's medicines.

People were protected from the spread of infection. The provider had a policy in place to prevent and control the spread of infection and staff were observed using personal protective equipment when providing care to people. The home was clean and there were no unpleasant odours.

There was a reflective culture within the service. The provider had a system in place for reporting incidents and accidents such as falls. Records we reviewed showed staff analysed incidents and implemented safety measures to help prevent reoccurrences. This helped staff to reflect on incidents and develop action plans to prevent future incidents to maintain people's safety.

Good

# Is the service effective?

## Our findings

People we spoke with told us they received care which met their needs. One person told us, "The GP comes whenever you need." Another person said, "Excellent staff, friendly and respectful. They care, I can't say enough for them."

People's needs and choices were assessed and recorded in their electronic care plans, which were regularly reviewed and updated. During staff handovers, changes to people's needs were shared with members of the staff team. Staff used nationally recognised, evidence based assessment tools to assess people's needs and develop care plans. These included the 'Waterlow' and 'Brandon' tools for assessing a person's risk of developing a pressure ulcer.

Records showed these assessments were reviewed at least monthly. One person had been assessed as being at risk of developing pressure ulcers due to their immobility. Staff had made the community nursing service aware and an air mattress and pressure relief cushion had been supplied. The person had not developed any pressure ulcers.

People were supported by staff who had completed the appropriate training. Staff completed an induction before commencing work which incorporated the Care Certificate. The Care Certificate is a structured programme which ensures staff are sufficiently trained and skilled to meet the needs of the people they support. The provider used appraisals and regular supervisions as opportunities to identify training needs. Staff competencies were checked regularly.

Staff were supported by their managers with a structured supervision programme. Staff files we reviewed contained evidence of regular appraisals and one to one meetings. In addition, staff completed medicines administration competency observations.

People were supported to have sufficient amounts to eat and drink. People were offered a choice of meals which met their nutritional needs. The head chef worked with senior care staff to identify people at risk of malnutrition. Meal supplements and fortified foods were then provided for those people.

When people needed support from different agencies and services, records showed that staff worked in partnership with professionals such as specialist safeguarding practitioners, nurses, GPs and social workers to ensure people's health and wellbeing needs were met.

When a person needed to be transferred to hospital, copies of their care plan and medical details could be printed from the care planning system in the form of a 'Hospital Pack'. This helped ensure that any healthcare professional treating the person could give the correct treatment as they had access to up to date information about the person's health needs.

The home was purpose built with many accessible communal areas both inside and outside the building. There were themed areas along corridors such as a seaside area that contained photo collages and a fishing

net hanging from the ceiling. Staff had placed simple, coloured visual signs on bathroom and toilet doors to help people living with dementia orientate themselves. Staff had also placed 'memory boxes' filled with objects of sentimental value and photos outside people's doors to help them find their rooms.

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the Mental Capacity Act (2005). The procedures for this in care homes are called the Deprivation of Liberty Safeguards. The registered manager had applied for authorisations under the safeguards for people where necessary and maintained an up to date record of applications. Staff had been trained in the Mental Capacity Act and were competent to apply its principles when caring for people. Records contained evidence of best interest meetings held.

Requires Improvement

# Is the service caring?

## Our findings

During our inspection we observed that some members of staff did not respond promptly to some people showing signs of distress. During the second day of inspection we observed a small group of people sitting in an alcove next to the staff office of the specialist unit for people living with advancing dementia. Staff could view the seating area through the window. There was very little interaction with people during a period of over two hours. One person was calling out for their relative and appeared to be distressed and confused. Several members of staff were present, however, no one responded to this person. Another person was observed hitting the person sitting next to them. We spoke with a staff member about this incident. They said "Oh, that's [person]." Several staff members were also observed having conversations with each other around this group of people. There were several missed opportunities which staff could have taken to provide emotional support, reassurance and have meaningful interactions with people during this period. This meant that people's needs for emotional support were not being met, as staff were not responding to them in times of distress.

People did not always receive personalised support that met their individual needs. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Person-centred care.

People at the home were treated with dignity and respect and their independence promoted. One person told us staff supported them to complete tasks independently. They said, "They watch but they don't interfere. I go to do the laundry and use the washing machine as I used to do at home. Then I dry it here naturally how I like to do it." Another person told us, "I have this little refrigerator here in my room and I keep my food here. They accommodate my needs. The staff are helpful." Most staff were sensitive to people's needs and helped people only when they required assistance. During our meal time observation on the first day of inspection, one person in the dining room wanted to use the toilet but was unsure where it was, A staff member helped them, but did so discreetly so as not to draw attention to them.

Staff used different methods to seek people's views on care provided. We reviewed the monthly residents' meetings minutes for the four months prior to the inspection. At the meetings, the outcomes from the previous meeting were read out and staff had written people were 'happy' with these. People were asked their opinion about housekeeping, catering, care provision, maintenance and activities. There were no major issues or concerns recorded.

Requires Improvement

# Is the service responsive?

## Our findings

People had care plans in place that were based on assessment of their health and wellbeing needs, including communication, emotional support, mobility and skin conditions. Plans were kept electronically and evidence showed these were reviewed by staff at least monthly. Staff could access care plans via mobile handheld devices and computers based in care offices located on each unit. The first screen gave a shortened version of the person's basic needs, such as mobility and nutrition, along with a record of any interventions, such as meals, drinks and personal care the person had received that day. In order to access the care plans on mobiles or computers staff used a unique user identity and password. This ensured people's information was secure.

Care plans contained guidance for staff about how people needed their care delivered. However, language used by some staff in some people's care plans wasn't person centred. In addition, some care plans lacked sufficient detail for staff to deliver care which met people's needs. Several people at the service were living with dementia. In one person's care plan, staff had written, 'There are times when [the person] is very challenging and difficult'. This presented a negative view of the person and showed staff lacked insight into the person's condition and support they required for their health and wellbeing.

In a further example, a care plan lacked information on how staff should support a person when they became anxious. Staff had written, 'Staff are to continue to reassure [person]' and 'Care staff to provide emotional support in events of [person] becoming anxious or depressed.' There was no information relating to any triggers that might affect the person's behaviour or any actions staff might take to relieve distress, such as distraction techniques. This meant the person's emotional needs were not being met, as staff did not have sufficient guidance to refer to when the person needed support in periods of anxiety or distress.

In another example, staff had written, 'Staff need to answer [person] promptly as to [their] location as [their] frustration as to not knowing where [they are] can quickly lead to [person] becoming verbally and physically aggressive.' On the first day of the inspection we observed this person sitting with their relatives, laughing and joking. When the carer came to give them their medicines, the person also laughed and joked with them. The information in the care plan was negative and did not reflect the person's positive qualities and could lead to them receiving care which was not personalised and did not support their needs.

People did not always receive personalised support that met their individual needs. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Person-centred care.

The deputy manager told us there was a varied activities programme for people led by an activities coordinator. This included bowls, chess, summer barbeques and arts and crafts. They said, "We have the big word game for the over 60s, games and crafts…we had a [person] who wanted to go back to Ireland - we brought the Irish party to them." The deputy manager showed us an art room which contained art work created by groups of people living in the home. This work had been displayed around the building and helped people feel a part of the home's community.

There was a chapel in the home which was used by people and staff for services and quiet reflection. In addition, the deputy manager told us a quiet space was used by staff and people of different faiths.

The provider sought feedback from people and their relatives using written and verbal methods. People and their relatives were encouraged to give feedback about improvements they would like to see in the home. A 'Grumble Board' was situated in the reception area on which people or their relatives could add any suggestions for improvement. One suggestion was that books were provided for people living on one of the residential units. We saw that two bookcases and books had been provided.

Staff gathered people's opinions on care provided. Quality assurance questionnaires were sent out to residents, relatives and health professionals annually, the last being in January 2018. A 'Quality Assurance Analysis and Action' document was produced, dated January 2018, which summarised the findings of the audits. Results indicated that most people who responded were positive about the home and the support they received.

We reviewed the provider's complaints file, which showed complaints had been dealt with promptly and any actions taken had been recorded. Actions included individual staff supervision sessions and meetings with complainants.

The service was not supporting anyone receiving care and treatment during their last days at the time of our inspection. Staff had recorded information about care people wished to receive at the end of their lives. People's care plans contained brief details about the treatment they wished to receive and the place they wished to remain in during their last days. There was also information about people's preferred funeral arrangements and which relatives to contact in case of an emergency.

Requires Improvement

# Is the service well-led?

## Our findings

Systems were in place for managing quality and safety within the service. The registered manager maintained an oversight of required service developments through completing regular audits which informed the overall service development plan. The registered manager also delegated responsibility for completing audits to senior members of staff, the results of which were incorporated into the development plan. However, these were not fully effective in addressing improvements in quality and safety.

We reviewed the actions from audits completed by senior carers in medicines management. Audits we reviewed from the six months prior to inspection showed errors and omissions had been identified and staff had stated these had been addressed. However, there was insufficient detail to show how these errors had been corrected or whether actions identified in previous audits had been completed. For example, in an audit we reviewed dated July 2018, staff had written, 'lots of gaps from both day and night staff'. Staff had signed the audit to say that action had been taken to address these mistakes but we were unable to find evidence of this in the July audit, or evidence actions had been reviewed or completed in the following audit from August 2018.

In a further example, in an audit from September 2018, staff had stated there were 'gaps on mars [medicines administration records] from night staff.' In the audit for October 2018, staff had written 'gaps on two resident's night meds'. These audits indicated actions staff had taken to correct errors had not been effective as mistakes were repeated.

After the inspection the provider sent us evidence of a competency assessment completed by a senior staff member on one member of staff. However, we could not be assured that the provider had produced sufficient evidence to show all errors and omissions identified in the audits had been addressed. This meant we could not be assured all actions were being identified, taken and reviewed to mitigate risks in the management of medicines, which may put people at risk of harm through receiving medicines from staff who did not have the appropriate competencies.

The provider had not ensured appropriate and effective quality assurance processes were in place to assess, monitor and improve the quality and safety of the services provided. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

People we spoke with told us the registered manager and senior management team were approachable and available. One person said, "The manager comes to see me quite often." Another person told us, "I'm impressed with the staff. They always have a big smile on their face…the manager is delightful." A third person told us, "I see the staff and management through the day and I can speak with them.'

The registered manager and senior team told us they were committed to delivering individualised care for people which met their needs. There was a clear management structure in place with defined roles. The registered manager was supported by a deputy and assistant manager. Team leaders had responsibility for managing the four units within the home. They were supported by senior carers and care staff. The

registered manager had also nominated champions in areas such as falls prevention, dementia support and safeguarding. Champions took responsibility for providing support and guidance to other members of staff.

People who use the service, staff and the public were engaged in the service. Staff were encouraged to take up areas of responsibility and engage in further training. Staff had made links with a local bowls club and invited relatives into the home once a month for a 'Dementia café' to provide support and guidance to people and their relatives. Staff had also linked with a local nursery. The deputy manager told us the children made regular visits to the home.

People and their families gave regular feedback on developments they wish to see in the home. The registered manager told us relatives felt comfortable speaking with staff. They said, "My staff are very good at chatting, [the] door is never shut…families will pop in…they don't feel they can't come in here." This meant relatives could uphold their loved one's wellbeing as they were able to approach staff with any concerns.

The registered manager delegated responsibility to the deputy and assistant manager for areas of service delivery such as safeguarding and people's wellbeing. The deputy manager had undertaken projects to safeguard people and promote their wellbeing including the safeguarding project and wellbeing project, both of which were described earlier in this report. Manager's weekly and monthly meetings were held with heads of departments including care, maintenance and catering. This meant staff had a detailed understanding of necessary service improvements and budgets.

The registered manager maintained an up to date log of accidents and incidents. Staff reflected on incidents, as well as on care provided as a means of making improvements and of preventing accidents reoccurring. Records showed that when incidents occurred staff put suitable measures in place to prevent reoccurrences, such as mobility equipment and extra staff support for people.

All services registered with the CQC must notify the CQC about certain changes, events and incidents affecting their service for the people who use it. Notifications tell us about significant events that happen in the service. We use this information to monitor the service and to check how events have been handled. The service had notified CQC about all incidents and events required.

Staff liaised with agencies such as health and social care to meet people's needs. Records showed and staff confirmed that they worked in partnership with a number of health and social care professionals to promote that people's health and wellbeing. Care plans we reviewed showed people were supported to have access to health care services and professionals when they needed it, including general practitioners and community nursing and mental health teams.

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<br><br>People did not always receive personalised support that met their individual needs.<br><br>This was a breach of Regulation 9, 3. (a) (b) (f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Person-centred care. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>The provider had not ensured appropriate and effective quality assurance processes were in place to assess, monitor and improve the quality and safety of the services provided.<br><br>This was a breach of Regulation 17, 2 (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) 2014. Good Governance |