Roja Limited

Richmond Care

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service: Richmond Care is a 'care home' that provides both residential and nursing care. The service can provide care for up to 19 people. There were 18 people with enduring mental health needs and other complex needs living at the home, although two people were in hospital at the time of this inspection.

People's experience of using this service:

Medicines were not being managed safely. A recent medicine audit had not picked up the errors we found.

The number of staff available during the day and at night was sufficient to ensure people's needs were met in a timely way at the time of the inspection, due to additional resources in the home. We were not confident that normal staffing levels would meet people's needs, especially with people's increasing dependencies.

The home was clean. Audits in this area were fit for purpose and any identified failings were rectified.

Environmental health and safety checks had been carried out but had not identified some of the issues we identified. The system for reporting and addressing repairs required to the home needed to be formalised. Risks to people's health, safety and well-being associated with their care needs were assessed and management plans were in place to ensure risks were mitigated as much as possible.

The management and staff understood their obligations under the Mental Health Act 1983 and worked within these legislative frameworks.

Care plans reflected that care was being delivered within the framework of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards had been applied for when necessary.

People told us they felt safe and well cared for at the home. Staff knew people well and had developed close, caring relationships. Staff were aware of their responsibilities to safeguard people.

Recruitment practices were safe and staff received the training they required for their roles.

People and their relatives were involved in making decisions about their care.

People who were independent were able to access the community and engage in meaningful leisure and social activity. There were less opportunities for people who required support from staff to do this.

Audits of the service were in place and were undertaken, although these were not always used effectively to monitor and improve the quality and safety of the home.

The manager was using available resources such as the local registered manager network and meeting with

relevant health professionals for advice and guidance.

We identified two breaches of the regulations and we made three recommendations. These included introducing a formal process to determine staffing levels, improving the way required repairs were reported and dealt with and engaging people more in meaningful social activities.

The home met the characteristics of a rating of "Good" for two key questions and "Requires Improvement" for three key questions. Our overall rating for the home after this inspection was "Requires Improvement".

Rating at last inspection: At the last inspection in October 2016 the home was rated Good (report published 31 October 2016).

Why we inspected: This was a planned inspection based on the rating at the last inspection.

Please see the 'action we have told the provider to take' section at the end of the report.

Follow up: We have asked the provider to complete an action plan detailing how they will make improvements to ensure the regulations are met. We will work with our partner agencies, including the local authority, to review the progress made by the provider. We will continue to monitor the intelligence we receive about the service. If any concerning information is received, we may inspect sooner.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not always safe.	**Requires Improvement**
Is the service effective? The service remained effective.	**Good**
Is the service caring? The service remained caring.	**Good**
Is the service responsive? The service was not always responsive.	**Requires Improvement**
Is the service well-led? The service was not always well led.	**Requires Improvement**

Richmond Care

Detailed findings

Background to this inspection

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

Inspection team:
One adult social care inspector undertook this inspection.

Service and service type:
Richmond Care 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.

The service had a manager registered with the Care Quality Commission. A registered manager means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection:
This inspection was unannounced.

What we did:
Prior to the inspection, we reviewed information we held about the home including statutory notifications. A statutory notification is information about important events, which the provider is required to send us by law. The provider completed the required Provider Information Return. This is information providers must send us to give us key information about the service, what it does well and improvements they plan to make. We took this into account in making our judgements in this report.

During the inspection, we used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk to us. We observed

support being delivered in communal areas and we observed how people were supported during the day.

We spoke with four people living at the home. We also spoke with the registered manager, the deputy manager, a nurse, two care workers, a student nurse, the cook and the housekeeper. We reviewed the care plans for three people, the recruitment files for three members of staff and looked at records relating to the management of the home. These included how the home managed people's medicines, health and safety audits, quality monitoring systems, training records, accident and incident records; surveys; meeting minutes and complaint records.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm

Some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed. Regulations may or may not have been met.

Using medicines safely:
• Medicines were stored safely however processes need to be more robust to ensure people received their medicines accurately and safely.
• Not all medicines administration records (MARs) included a photograph of the person receiving the medicine. This was particularly important as the service used agency nurses on occasions. Agency staff might not be able to identify people living in the home, therefore a lack of photographs can increase the risk of medicine errors.
• We identified errors on the MAR charts we looked at; for example, some nurses were using a single letter instead of two initials, to indicate medicines had been administered. The use of a single initial could easily be confused with a separate key on the MAR, indicating various reasons why medicines had not been administered, for example if a person refused medicines or was asleep.
• It appeared that one person had missed a medicine for two days although this was disputed. As the MAR chart for this medication could not be located it could not be proven that the person had received all their prescribed medication.

This demonstrated a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
• We identified that on the days of inspection there were sufficient staff employed at the home to meet people's needs. At the time of the inspection the registered manager told us 3 care workers were on duty during the day, plus a senior member of staff, who assumed responsibility for administering medicines. Staffing levels then reduced to one senior and two support workers during the night. Rotas we saw confirmed this.
• The number of permanent staff were boosted by two student nurses, who were supporting people in the home as part of their course placement. Both student nurses were due to leave the service within a week of our inspection ending. Two people in hospital at the time of this inspection were due to return to the service and both had high dependency needs. The service was also arranging a new admission.
• We voiced our concerns to the manager as we were not confident that normal staffing levels would be adequate to manage the needs of all the people living in the home, given the number of people with high dependency levels. The registered manager told us that day support would be increased to four care workers once the service was full.
• Some staff we spoke with commented that people would benefit from having more staff available to support them. Staff we spoke with working at the service recognised the value of the student nurses and told us, "They [the student nurses] have been a big help whilst they've been here."

• The provider did not have a system in place to help determine the number of staff required on duty to meet people's individual needs.

We recommend that the provider reviews its staffing levels and implements a formal way of calculating how many staff are required to ensure individual needs are appropriately met.

• We looked at three personnel files during the inspection and found recruitment practices were safe. This included carrying out disclosure barring service (DBS) checks, seeking references from previous employers and the provision of mandatory training.

Preventing and controlling infection
• Measures were in place to prevent and control the spread of infection and we found the home to be clean.
• Audits were undertaken, and any identified shortfalls were addressed in a timely way. For example, we saw one audit had identified a torn mattress. This presented an infection control risk so a new mattress was ordered and supplied.
• Food preparation and storage areas were clean.
• Staff had access to gloves and aprons to reduce the risk of cross infection and we saw staff wearing these during the inspection.

Assessing risk, safety monitoring and management
• Whilst records showed that checks were carried out on the building we noted some maintenance issues around the home had not been addressed. Not all wardrobes were secured to walls and we noted a faulty coded lock on a door at the top of a set of stairs. This had been reported but it was not fixed or replaced during our inspection.
• It wasn't clear what processes were in place to report and address repairs in the home and the maintenance man was not available during the days of inspection to check this.
• We saw that checks had been made on fire safety and moving and handling equipment and the environment was free from clutter to reduce the risk of trips and falls.
• A passenger lift provided access to all areas of the accommodation making them accessible to people with limited mobility. We saw that the required service checks had taken place and no category A faults, those requiring immediate attention, or observations had been noted. The next service was due on or before 1 May 2019.
• Risk management plans were in place and were accessible to staff. Risk assessments contained information staff needed to manage and mitigate risk. We saw staff took appropriate action to manage people's anxiety levels and de-escalate any potential risks.
• An extension was being built to the rear of the home at the time of this inspection. The registered manager had put measures in place to minimise the disruption to people living at the home. They had also consulted with the fire brigade so that the home remained compliant with regards to fire safety.

We recommend the service adopts a formal system to ensure repairs are reported and addressed in a timely manner to ensure people living at the home are kept safe.

Systems and processes to safeguard people from the risk of abuse
• Those people who could share their experiences with us told us they felt safe at the home. One person we spoke with told us, "[I feel] very safe indeed." They told us they were able to use a call bell in their bedroom if they needed help and support from staff. • Information and training provided staff with guidance about what to do to make sure people were protected from harm or abuse. Staff were able to tell us what steps they would take if they suspected people were being abused.

Learning lessons when things go wrong

• Evidence was available to show that when accidents had occurred the manager responded appropriately and used any incidents as a learning opportunity. Following any accidents or incidents a thorough report was compiled to ensure people were kept safe and staff responded appropriately by informing relevant professionals.

• In 2018 the service had informed CQC that a nurse working at the service had allowed their personal identification number (PIN), to lapse. No one had come to harm and the service could evidence lessons had been learned with the mechanisms put in place to prevent a repeat of this incident.

Good

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence

The effectiveness of people's care, treatment and support achieved good outcomes or was consistent. Regulations were met.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law:
• The home's pre-admission assessment was comprehensive. We were assured that people living at Richmond Care were appropriately placed, and the service could meet their needs. The assessment forms contained information related to people's medical, physical and emotional needs including levels of support required and any known risks.
• Prior to a person being admitted to the service multi-disciplinary meetings were held to ensure that the service could meet the person's needs. The manager told us that the needs of the people currently living in the home were considered prior to any new admissions and compatibility with proposed new residents was assessed.

Ensuring consent to care and treatment in line with law and guidance:
• 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, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.
• Restrictions of people's liberty were being managed lawfully. For example, some people were unsafe to leave the home without support, and authorisation had either been sought from or given by the local authority.
• Staff had received training in the MCA and we saw they asked people for consent prior to providing care and support. Staff encouraged people to make decisions about their lives.
• Where people were not able to make a decision, including where restrictive practices were being considered, a best interest decision making process was followed. This included consideration of the least restrictive options and these decisions were well documented.
• We saw examples of independent advocates being involved in best interest decisions.

Staff support: induction, training, skills and experience:
• Staff received the training they required to do their job which included care related topics as well as health and safety issues.

• Staff told us they were well supported and had the opportunity to discuss their training and development needs with the management team. Regular supervisions were being recorded and staff said they could approach the management team at any time if they had a problem.

Supporting people to eat and drink enough to maintain a balanced diet:
• Guidance had been sought and was being followed for those people at risk of choking due to swallowing difficulties. Specific dietary information was shared with the cook so that meals were appropriately prepared for people.
• The service had been awarded a food hygiene rating of 5, the highest possible rating. The inspection had looked at the cleanliness and condition of the facilities and the building in relation to good food hygiene and judged this to be 'very good'.
• Support was provided for people to be as independent as possible with eating and drinking. Where support was required, staff provided this in a discreet manner.
• People could eat meals where they chose. Staff promoted choice and knew people's preferences with regards to where they liked to eat their meals.

Supporting people to live healthier lives, access healthcare services and support: Staff working with other agencies to provide consistent, effective, timely care:
• We reviewed care records and noted there was a multi-disciplinary approach to meeting people's individual needs. For example, we saw evidence of input from psychiatrists, care co-ordinators, doctors, district nurses and dentists.
• Staff notified relevant professionals and family members promptly following any identified changes in need.

Adapting service, design, decoration to meet people's needs
• Bedrooms were personalised if this was the person's choice. One person loved a specific local football team and we saw their room had been personalised accordingly with team colours, football pictures, a scarf and a door sign.
• Toilets and bathrooms were adapted to the needs of people with limited mobility.
• A new extension to the building was underway at the time of this inspection. The service had recognised that more room was needed. The extension would provide additional bedrooms, a larger clinic room and more communal space.
•The home was a grade two listed building and the provider had retained some original features, including the windows. We saw that frosted, opaque film had been applied to the bottom halves of all the windows at the front of the home. This ensured the privacy of the people that lived at Richmond Care was maintained, whilst still allowing natural light in to the home.

Good

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect

People were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported:
• People were supported by staff who knew their needs, personalities, likes and dislikes well.
• Our observations showed staff were patient, kind and friendly when attending to people. We observed staff talking to people about news items and what interested them, for example football, to help engage with them.
• Even when staff knew people could or would not respond verbally, staff still engaged with them and asked how they were. Staff knew what was important to people and respected this.

Supporting people to express their views and be involved in making decisions about their care:
• People when able, were involved in creating and reviewing their care plans. On one day of our inspection we saw one person involved in a review of their care with other health professionals. The meeting was held at the home to help with this.
• People's views were sought, listened to and used to plan their care.
• Care plans included information about people's personal, cultural and religious beliefs. We saw that one person's culture was acknowledged and respected by the food that was specially prepared for them. The cook showed us the batches of culturally-specific meals made for the person so that they could enjoy the food they liked to eat on a daily basis.

Respecting and promoting people's privacy, dignity and independence:
• Staff were keen to ensure people's rights were respected and not discriminated against regardless of their disability, culture or sexuality. One member of staff said, "Everybody is different. I respect that. We all do. It's important to treat people as you would want to be treated."
• Staff had received training on equality and diversity and respected people's wishes in accordance with the protected characteristics of the Equality Act.
• People were supported to maintain and develop relationships with those close to them. There were no restrictions on visitors.
• People's right to privacy and confidentiality was respected. Staff were seen to be discreet when asking people if they required support with personal care. If help was refused or people did not answer staff were gentle in their approach, providing words of encouragement. If people chose not to engage then staff withdrew and gave them space.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs

People's needs were not always met. Regulations may or may not have been met.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control:
• People who were able to leave the home independently, could access the community and engage in meaningful leisure and social activity. One person we spoke with told us, "I like to get out. I go out for brunch. I go to Didsbury." There were less opportunities however, for people who required support from staff to do this.
• Some people we spoke with were happy to stay in their room or socialise with others in communal areas of the home. One person liked to crochet and was supported to do this.
• However, one person relatively new to the home told us they would like to go out but had not yet been supported to do so. We looked at their care plan which had been formulated on admission more than three months prior to this inspection. This indicated staff would plan SMART goals with [person] and do appropriate activities of their choice but these had not yet happened.
• The home did not employ an activity co-ordinator and we saw no attempt from care staff during our two days of inspection to engage people in the home in a group or individual activity within the home.

We recommend that further consideration needs to be given to providing engagement in social and leisure activities for people living with mental health needs, especially within the service.

• Staff knew people well and could describe their likes, dislikes and preferences. Staff were aware of people's histories but were mindful that some aspects might cause distress and were careful when conversing with people. Interactions were light hearted and tended to be about current events.
• Care plans provided staff with descriptions of people's abilities and how they should provide support in line with people's preferences.
• Staff told us about how people who could no longer express themselves verbally communicated their needs. We saw staff responding well to people's non-verbal communication.
• The nominated individual told us that people were taken to the shops, to the local pub for lunch or to play pool. The home celebrated special events in the calendar, such as Valentine's Day and St Patrick's Day.

Improving care quality in response to complaints or concerns:
• People were provided with information about how to make a complaint and we saw that the service had a complaints policy and procedure.
• Records of complaints were maintained, and actions identified to resolve issues.
• The manager reviewed complaints and told us they used these as an opportunity to learn and make improvements.

End of life care and support:
• Where people's wishes were known about how they wished to be cared for at the end of their lives, this was

recorded in their care files. Where people had a Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) form in place, we saw a copy in the care plan and the registered manager was aware of this.

• People were supported to remain at the home if this was their wish when approaching the end of life.

Requires Improvement

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture

Service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care. Some regulations may or may not have been met.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care:
• The home had a registered manager in post which was a condition of the provider's registration with CQC. There was support for the manager from the provider as the nominated individual was on site most days. Other administrative and financial support was provided by a small team of staff, located in basement offices.
• We saw examples of audits undertaken although these were not always used effectively to monitor and improve the quality and safety of the home. For example, we found some environmental issues had not been addressed, errors and poor practice with the administration of medicines had not been identified and staffing levels had not been determined through the use of dependency assessments.

This demonstrated a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Prior to our inspection we checked the provider's website and saw that the rating awarded at the previous inspection was not displayed, as is the law. This rating was on display in the home. We discussed this with the nominated individual and the registered manager. They told us the website was due to be updated but following this inspection later added the rating to the website.

Working in partnership with others; engaging and involving people using the service, the public and staff, fully considering their equality characteristics:
• The registered manager sought views from people, their relatives and staff about how well the home was supporting people, although external healthcare professionals had not been consulted and the number of responses from staff had been low.
• People living in the home had been formally consulted about the types of meals on offer and we saw that the registered manager had acted on people's feedback, for example by changing the menus to meet people's requests. As a result of a survey, two meals suggested by people were now included in weekly menu choices.
• The manager was using available resources such as the local registered manager network and meeting with relevant health professionals for advice and guidance.
• Staff meetings provided staff with the opportunity to share their views with the management team and for important information to be discussed. Staff told us they felt listened to and were supported by the management team.
Planning and promoting person-centred, high-quality care and support with openness; and how the

provider understands and acts on their duty of candour responsibility:
• The registered manager was aware of their obligation to notify CQC of all of the significant events occurring within the home.
• The registered manager acknowledged the provision of activities for people living at Richmond Care had slipped. They recognised this was a priority and were working with the deputy to address this.

• The home informed relatives of any concerns with people's health or if an accident had happened, fulfilling their responsibilities of the Duty of Candour. A legal requirement to be open and honest when things go wrong.
• The management team and staff were responsive and keen to share information during the inspection.

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 12 HSCA RA Regulations 2014 Safe care and treatment Medicines were not administered safely. We found errors and areas of poor practice that had not been picked up during medicine audits.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems established to monitor the quality and safety of the home were ineffective. Audits had not identified the issues we found with the environment and management of medicines.