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Riccall House Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Riccall House Care Home is a residential care home providing personal care and support to people aged 65 and over, some of whom were living with Dementia. Riccall House Care Home is an adapted building across two floors. At the time of the inspection there were 15 people using the service. The service can support up to 18 people.

People's experience of using this service and what we found

There was a clear lack of systems and processes in place to monitor the quality and safety of the service. Some policies and procedures were not in place or were not in line with current guidance.

Some staff had not received essential training and other training had not been refreshed in line with the providers own timeframes. Checks were not in place to ensure they were competent in carrying out their duties.
Records relating to risks to people had not always been regularly reviewed and care plans were not always updated to reflect the current level of need and support for the person. Risks in relation to the environment has not always been considered. Systems were not in place to effectively monitor accidents and incidents within the service.

Medicines were not managed safely and staff administering medications were not always trained to do so. We also identify some issues around medicines records and storage of medication that required improvement.

Infection prevention and control policies and procedures were not up to date and did not reflect current government guidance. Additional cleaning and checks in response to the COVID 19 pandemic were not in place and risk assessments were not completed for individuals at risk as a result of infectious outbreak.

Staff were familiar with people and their care and support needs. Staff worked well as a team but they did not always feel listened to by the registered manager.

Feedback from people who used the service and their relatives was positive and they found staff to be caring and kind. People told us "I'm so lucky to be here" and "The staff are caring. You get well looked after in every way."

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

We discussed several issues with the registered manager during the inspection and asked them to take

action to address immediate risks. We also asked that they update some records relating to risk and take steps to reduce risk around infection prevention and control (IPC). Other areas requiring improvement are ongoing and we will ask the provider to inform us when these have been completed.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk
Why we inspected
The last rating for this service was good (published 21 November 2019).

Why we inspected

We undertook this targeted inspection to follow up on specific concerns which we had received about the service. The inspection was prompted in part due to concerns received about infection prevention and control (IPC). A decision was made for us to inspect and examine those risks.

We inspected and found concerns with the management of IPC so we widened the scope of the inspection to become a focused inspection which included the key questions of safe and well-led.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to coronavirus and other infection outbreaks effectively.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

We have found evidence that the provider needs to make improvements. Please see the Safe and Well-led sections of this full report. The provider had taken some action during the inspection to mitigate risks and continued to liaise with the inspector after the inspection to advise of further improvements scheduled and/or carried out.

You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Riccall House Care home on our website at www.cqc.org.uk.

Enforcement

We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to medicines management, risk assessments, staffing and monitoring of the service at this inspection.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up

We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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

The service was not always safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Riccall House Care Home

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. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
The inspection was carried out by one inspector on the first day and two inspectors on the second day.

Service and service type
Riccall House is a 'care home'. People in care homes receive accommodation and nursing or personal care as a 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. This 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 announced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

We used all of this information to plan our inspection.

During the inspection

We spoke with three people who used the service and four relatives about their experience of the care provided. We spoke with six members of staff including the provider, registered manager, team leaders, senior care workers and care workers.
We reviewed a range of records. This included two people's care records and multiple medication records. We looked at two staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider and manager to validate evidence found. We received further evidence by email which we reviewed including risk assessments, policies and procedures.

Requires Improvement

Is the service safe?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant 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.

Assessing risk, safety monitoring and management

● Risks to people were not always safely monitored and managed. There was limited use of systems to record, manage and report concerns. Where safety concerns had been identified, timely action had not been taken to mitigate risks.

● Environmental risks had not always been identified or assessed. For example, there were no window restrictors in place. This put people at risk of falling from a height likely to cause harm. We raised this with the registered manager and action was taken to install window restrictors immediately.

● Risk identified by other professionals had not been addressed. For example, fire risks identified by an external contractor in July 2020 remained outstanding at the time of this inspection.

●The provider did not have sufficient audit processes in place to ensure checks were completed therefore issues had been left unnoticed.

●Risks relating to people's individual needs were regularly reviewed, however measures put into place to reduce known risk was not always documented.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●Referrals were made to healthcare professionals when needed. For example, a timely referral was made to a GP and district nurses when a person became unwell.

● The provider had invested in a new electronic system to record people's care and treatment which they were in the process of transferring care records on to.

●Following the inspection site visit the provider took action to address the issues raised in the fire risk assessment. We will continue to monitor progress.

Using medicines safely

●Medicines were not always managed safely.

●The service did not always follow relevant NICE guidance around secure storage of medicines. ●The service had a homely remedies policy, this was not in line with current NICE guidance.

● Some staff administering medication had not been provided with appropriate medicines training or had

their competencies in this area assessed to ensure they were providing safe medicine support to people.
● Where people were prescribed 'as and when required' medicines appropriate guidance was not in place for staff to follow. Sufficient guidance was not in place for staff in relation to topical medicines, such as creams and where they were to be applied.
● The provider did not have up to date procedures in place for staff to follow. Where people were prescribed 'as and when required' medicines, guidance for staff to follow were not in place. Staff therefore did not have all the information required to know when to administer them.

The provider had failed to ensure the proper and safe management of medication. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social
Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong
● Staff had not received up to date training in safeguarding and the provider did not have a clear safeguarding process in place.
●Some staff are not clear how to raise a safeguarding concern and told us that they did not know what whistleblowing is.
● Accidents and incidents were not monitored and analysed. Themes and trends were not identified or shared with staff to learn and improve the quality of the service.

The provider had failed to ensure systems or processes were established and operating effectively, this is a breach of regulation of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●People told us "I feel safe, the comfort and the care you get makes you feel safe" and "They [staff] are very pleasant people. When I have needed help I have got it."

Staffing and recruitment
●Safe recruitment processes were followed. However, there were gaps in some recruitment records. For example, interviews had not always been recorded and records were poor in relation to new staff completing a thorough induction to the service.
● People's dependency levels had been reviewed but this information had not been used to ensure there were a suitable number of staff on duty.
●The service did not always provide enough staff that have the right mix of skills and competence to support people safely. For example, night staff had not received medication training and were administering medications.

The provider failed to ensure there were suitably qualified, competent and skilled staff deployed this is a breach of regulation 18 (staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●During the inspection there were enough staff to meet the needs of people due to a lower number of people using the service. Staff told us, "at the minute there is enough staff but it was stretched during the pandemic and when we are full it is a struggle."
● The provider had recently moved to an online training system. Plans were in place to ensure all staff received relevant and up to date training.

Preventing and controlling infection

● People were not protected from the risk of infection. We could not be assured that the provider had taken steps to mitigate the risks to people's safety and welfare as a result of an infectious outbreak.
●Policies and procedures on infection control were not up to date and did not reflect current government guidance.
●Best practice in relation to infection control was not followed. Clear cleaning schedules were not in place.
●Not all staff have received appropriate training and did not not fully understand their responsibilities in relation to hygiene and infection prevention and control.
● Infection control audits were not in place. Appropriate waste disposal bins were not always in place, which increased the risk of contamination.

The provider failed to provide up to date guidance around preventing, detecting and controlling the spread of infections, this is a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●Following the inspection, the provider worked with the IPC team and took action to address some of the infection control concerns found.

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.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- The provider's systems to audit the quality and safety within the service were not always effective. Systems had identified some areas requiring improvement, but timely action had not always been taken. For example around actions identified in the fire risk assessment had not been actioned.
- Regular and robust monitoring and auditing of the risks to people was not sufficient. For example, risks in relation to the environment and infection prevention and control were not effective and did not identify the concerns we found during the inspection.
- Systems were not in place to record and monitor accidents and incidents. Trends and themes could not be identified to learn lessons when things went wrong.

The provider failed to ensure systems and processes were in place to assess, monitor and improve the service. This was a breach of Regulation 17 (Good Governance) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics;

- Feedback from people and relatives on the quality and safety of the service provided had not been sought.

- Staff told us that they worked well as a team and could approach leaders within the service. However, they did not always feel their feedback and suggestions about people's care were listened to by the registered manager.
- Relatives told us the registered manager was approachable. However relatives would like feedback on their relatives to be more proactive and initiated by the home.
- People told us "I get on very well with [registered manager's name]" and "I've never wanted to complain, but yes you could (complain if you wanted to). The staff are very close to everyone and you can talk to them at any time"

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong; Working in partnership with others

●Throughout the inspection the provider and registered manager demonstrated a positive approach to improving the service and acted quickly to feedback provided.

●The service worked well with other partnership agencies such as district nurses, GP services and the mental health team to ensure people receive specialist care when needed.

●The registered manager was keen to work with the local authority and clinical commissioning group going forward to improve the service.

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 The provider failed to assess the risk to the health & safety of service users and do all that is reasonably practicable to mitigate such risks. 12(2)(a)(b) The Provider failed to ensure that persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely. 12(2)(c) The provider failed ensure the proper and safe management of medicines. 12(2)(g) The provider failed to ensure guidance was implemented in relation to the prevention and controlling the spread of infections. 12(2)(h)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to establish and operate effective systems and processes to monitor and improve the service. 17(1) The provider failure to assess, monitor and improve the quality and safety of the service provided. 17(2)(a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed to ensure there were sufficient numbers of suitably qualified, competent, skilled and experienced persons deployed. 18(1)