Care Quality Commission

Methodist Homes
Richmond
Inspection report

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Date of inspection visit: 27 & 28 Jan 2016
Date of publication: 15/03/2016

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?	Requires improvement

Overall summary

We inspected Richmond on the 27 and 28 January 2016. This was an unannounced inspection. Richmond provides accommodation, care and support for up to 58 people. On the day of our inspection 55 older people were living at the home aged between 74 and 101 years. The service provided care and support to people living with dementia, risk of falls and long term healthcare needs such as diabetes.

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.

We last inspected Richmond on 11 March 2014 where we found the provider was meeting all the regulations we inspected against.

Throughout our inspection, people spoke positively about living at Richmond. Comments included, "Nice place to live" and, I'm very happy here." However, we identified a number of areas that required improvement.

Summary of findings

We found not all aspects of security had been considered by the provider in relation to visitors' access to the service outside of office hours. There were periods of the day when the number of care staff available impacted on their ability to respond in a timely manner to people. We found domestic staffing levels did not match the planned rota which had impacted on the quality of the domestic cleaning with the home.

The administration of medicines was seen to be safe and people told us they received their medicines promptly and correctly. However staff who were providing people with 'as required' medicines were not consistently recording why they had been given it. This meant patterns may not have been identified by staff in a timely manner.

Staff were unable to evidence what steps had taken to ensure a person who had been identified at risk of skin pressure areas was being regularly supported to check on this area of care.

Although people spoke positively about food at Richmond we found suitable systems to ensure food was hot when served had not been consistently implemented.

Although we saw many kind and caring interaction between people and staff we found occasions when peoples' confidentially and dignity was not consistently respected.

Peoples' were supported to be involved to follow their interests and take part in social activities however we found there were periods of time such as weekends when people told us there was not a consistent provision available.

People, their relatives and staff spoke highly of the leadership at Richmond. There were regular quality assurance checks however these had not always been effective at identifying the areas we saw required improvement. We found examples where records did not reflect an up-to-date picture of changing health support needs.

Appropriate checks had been undertaken when new staff were recruited at Richmond to ensure they safe to work within the care sector. Staff were trained in safeguarding and knew what action they should take if they suspected abuse was taking place. A range of training was provided to ensure staff were able to meet people's needs.

The CQC monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. We found that the registered manager understood when an application should be made and how to submit one. Where people lacked the mental capacity to make specific decisions the home was guided by the principles of the Mental Capacity Act 2005 (MCA) to ensure any decisions were made in the person's best interests.

Staff had a clear understanding of their roles and the philosophy of the home and spoke enthusiastically about working at Richmond and positively about senior staff. The registered manager and operations manager undertook regular quality assurance reviews to monitor the standard of the service which had been and drive improvement.

We found a breach in Regulation. You can see what action we told the provider to take at the back of the full version of this report.

Summary of findings

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.

Risks related to access to the home via the front door had not been adequately assessed.

There were occasions where there were not sufficient numbers of staff deployed to ensure people's safety and welfare was protected.

Medicines were managed safely however staffs recording of the reasons why people needed 'as required' medicines was not consistent.

People who used the service and relatives told us they felt safe with the staff that supported them. Risk assessments were in place to ensure people were safe within their home and when they received care and support.

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

Staff had a clear understanding of what to do if safeguarding concerns were identified.

Is the service effective?

Requires improvement

The service was not always effective.

Staff had not always evidenced they were responding to people's support needs.

People enjoyed meals times and the food however consistent systems were not in place to ensure all food was served hot.

A suitable training programme for staff had been established and was being delivered.

Staff had an understanding of the Mental Capacity Act 2005 and consent issues. Senior staff knew what they were required to do if someone lacked the capacity to understand a decision that needed to be made about their life.

Is the service caring?

Requires improvement

The service was not always seen to be caring.

People's dignity and confidentially was not consistently protected.

We saw kind and compassionate interactions between people and staff.

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

Is the service responsive?

Requires improvement

The service was not always responsive.

Summary of findings

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

Personalised information regarding people's daily routines was available to assist staff in supporting people with their preferred choices.

People and where appropriate relatives had been involved in the design of their care plans.

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

Is the service well-led?

Requires improvement

Systems for quality review were in place however had not identified all areas we identified as requiring improvement in regards to records.

Accidents were clearly recorded however audit data had not been not effectively o analysed.

Staff meetings were used as an opportunity to share and communicate key information on people and operational issues.

People spoke positively about the registered manager and senior staff.

Staff told us they felt supported in their roles and could approach the management about any concerns.

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 27 and 28 January 2016. This was an unannounced inspection. Three inspectors undertook the inspection.

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 sixteen people who live at the service, seven care staff, the chef, two domestic staff, a regional manager, the registered manager and their deputy. We also spoke to three people's relatives who were visiting the home during our inspection. We requested feedback from healthcare professionals who have routine contact with people who live at Richmond.

Before our inspection we reviewed the information we held about the home, including the Provider Information Return (PIR). This is a form in which we ask the provider to give some key information about the service, what the service does well and improvements they plan to make. We 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

People told us they felt safe living at Richmond. One said, "Oh definitely, always feel safe here, never worry about that." Although all people and relatives told us they felt confident the service was safe we found aspects of the service which were not safe.

The home's main entrance was accessed by automatic sliding doors. To get in or out of these doors an entry code was required. During our inspection we saw some relatives were letting themselves into the home using the code. An administrator who sat overlooking the front door acknowledged visitors arriving however they worked office hours. The provider had a risk assessment in place for the front door however the assessment had not taken account of relatives having the access code to the main door. This meant that there was an increased risk to peoples' safety outside of office hours and at weekends. For example a visiting relative could be followed into the home by someone who did not have permission to be there and would not be challenged by staff. There was also a risk that visitors would not sign in or out of the visitor book and if an emergency evacuation was required staff and emergency services could not be assured who was in the home. We raised this issue with the registered manager who told us only a 'select handful' of relatives had been provided with the access code but was unable to specifically identify who they were. The registered manager informed us shortly after our inspection had finished that they had changed the codes to the front door and all visitors were now required to press the entry bell so staff could decide who gained entry to the home.

The home had a hairdressing room which was used by people for hair appointments twice a week. We found a note on a ledge outside the room that stated the door should be kept locked when they were not present due to 'dangerous chemicals' being stored inside. However this note also had the door entry code written on it. This meant there was a risk a person may have been able to gain unauthorised access to this area.

The issues we identified related to areas of the premises being secure are a breach of the Health and Social Care Act 2008 Regulation 15 (Regulated Activities) Regulations 2014.

We found there were times of the day when staffing levels for carers and domestic staff impacted on the safety and quality of the service at Richmond. Care staffing levels matched what was published on staff rotas. The 25 people living on the ground floor were supported by four care staff and a senior carer between the hours of 8 am to 8 pm. The 30 people living on the first floor were supported by four care staff and one senior carer between 8am to 2pm however this dropped to three carers and one senior between 2pm to 8pm. In the afternoon on the first day of our inspection we found this reduction in staff on the first floor impacted on call bell response times. Staff told us they thought the first floor required additional staff in the afternoon. One said, "There are not enough of us to always respond quickly." Another said, "We are spread too thin up here." We looked at the records related to the number of falls people had during December 2015 and more than half occurred between 2pm and 6.30pm. Some people on the first floor required two staff to support them with moving, we saw whilst the senior carer was undertaking medicines this left one carer available to support people and respond to call bells. We saw examples of care staff being rushed, for example we saw one staff member respond to a call bell whilst wearing their meal time apron. Staff wear aprons at mealtimes to promote good food hygiene and reduce the risk of cross contamination from their clothes to the food they are serving. Another person who had been assisted by two care staff had not had their senor mat put back after staff had finished supporting them. An inspector alerted staff to this and the mat was returned to its usual position. The staff member said, "That was my mistake, it has been pretty busy and things can get forgotten." We raised our concerns regarding people's safety and staffing levels with the registered manager and on the second day of our inspection an additional member of care staff was allocated to the first floor for the afternoon shift. We saw and staff told us this additional member of care staff improved their response times to people's call bells.

On the first day of our inspection there was one domestic cleaner on duty. They were responsible for cleaning some communal areas and 55 bedrooms. They told us this was not usual and there were supposed to be two domestic cleaners working, one per floor. However records identified during the first 27 days of January there had been 13 days where the planned cleaning schedule had not been completed due to domestic staffing shortages. The domestic cleaner told us that when only one domestic cleaner was available then a reduced cleaning routine was undertaken. This meant tasks such as dusting and

Requires improvement

Is the service safe?

vacuuming people's rooms was not completed. On the first day of our inspection we saw people's rooms and communal areas required vacuuming. We raised this issue with the registered manager who although was aware domestic staffing required additional hours was not aware of the impact this had within the home. On the second day of our inspection a second domestic cleaner was on duty and we saw vacuuming and dusting was being completed. The registered manager told us a new member of domestic staff was scheduled to start soon and they would ensure the domestic staffing levels would be reviewed.

The issues identified relating to staffing levels requires improvement.

We saw records that evidenced electrical PAT testing was routinely undertaken on portable equipment. However we found some electrical equipment in people's rooms which the registered manager was unable to confirm whether it had been tested. The registered manager told us occasionally people's relatives brought in additional electrical equipment and although it was visually checked by the provider's maintenance person there was no record this had been completed. This is an area that requires improvement.

People commented they received their medicines on time. One person told us, "I always get the help I needs with my pills." However, we identified areas that required improvement with the management of medicines. Some people who lived at Richmond were prescribed 'as required' medicines known as PRN. We saw people had a PRN protocol in place to provide guidance for staff. However some people's PRN protocols for pain relief medicines stated for 'general pain'. It had not been clearly identified on people's Medication Administration Records (MAR) why they had given the PRN medicine, for example, one person had been given pain relief medicine for five consecutive days however there was no reason identified on their MAR. This meant there was an increased risk that a reoccurring pattern of pain could be overlooked and not referred or investigated appropriately.

However, we found all other administration related to medicines was safe. We observed medicines being administered. The senior care staff who administered the medicines checked and double checked at each step of the administration process. Staff also checked with each person that they wanted to receive the medicines.

Medicines were ordered correctly and in a timely manner that ensured medicines were given as prescribed. Medicines which were out of date or no longer needed were disposed of appropriately. One staff member told us, "I am confident doing medicines, the training and competencies are good."

Staff were able to confidently describe different types of abuse and what action they would take if they suspected abuse had taken place. There were up-to-date policies in place to ensure staff had guidance about how to respect people's rights and keep them safe from harm. These included clear systems on protecting people from abuse. We saw that safeguarding referrals had been made appropriately to the local authority safeguarding team in a timely fashion. One staff member told us, "Keeping clients safe from harm is why we are here."

We saw routine health and safety checks were undertaken covering areas associated with fire safety and water temperature. 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, "Once things are reported they get fixed or sorted out quickly."

The service had clear contingency plans in place in the event of an emergency evacuation. The service had an 'emergency grab bag' available which contained information such as 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, record 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. Staff described the recruitment process they had gone through when they joined.

Requires improvement

Is the service effective?

Our findings

People were positive about living at Richmond. They told us they felt well looked after and enjoyed aspects of the service such as their meals. However we found areas of the service were not always effective.

One person's care documentation identified they were at high risk of developing skin pressure areas. Their care plan stated their skin needed to be monitored for any signs of skin damage. However their daily records identified they routinely refused all aspects of personal care included assistance with the application of creams. This meant it was unclear when care staff had last checked this person's skin for signs of damage. We spoke with staff regarding this person and although familiar with their behaviours and preferences they had not sought additional support from health care professionals for advice on how best to support this person in relation to this area of their care.

People had a choice as to where they ate their meals. We saw most people chose to eat in the dining rooms on their floor. Food was prepared 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 care staff served people at tables. We saw the catering assistant plated some food up prior to receiving an order which meant food saw seen cooling prior to being served. We saw some bowls of soup on the first day stood for more than ten minutes before being served to people; this meant the soup would not have been hot. Several people chose to eat their meals in their rooms; we saw care staff taking their plates to their rooms however they had not covered their plates with a cover. On the first day of our inspection there was a planned meeting where people met the chef to provide feedback. This meeting was well attended and we saw the meeting minutes identified that the issue of 'cold food' was raised as a concern when eating in the dining room. The chef 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.

The registered manager told us that due to ongoing care staff recruitment they were using agency care staff to cover some shifts. On both days of our inspection there was one member of agency care staff working. On the first day of our inspection the agency care staff member was working on the ground floor. The registered manager was unable to confirm whether this agency member of staff had undertaken training or had experience working in a service where people were living with dementia. This member of agency staff did not know people's names and relied on established staff to advise them. This meant they were not able to greet and orientate people living with dementia as effectively as established staff. We spoke to the deputy manager who had responsibility for the administration and deployment of agency staff. They told us this agency staff member had previously worked at the home however this had been on the first floor. The deputy manager told us they would plan carefully where an agency member of staff was deployed. They also told us they would work more closely with their supplying agency to ensure they were provided staff who had received training in dementia care.

However we found all other care staff undertook a range of training which was appropriate to enable them to effectively support people living at Richmond. Mandatory training included areas such as, infection control, moving and handling and fire training. Additional training such as nutrition and hydration and dementia awareness was also undertaken. Staff spoke positively about the training they were offered. One told us, "If you express an interest in a particular area you can be supported to learn more about it." Another said, "I found the dementia training useful as where I worked before this wasn't covered."

New staff completed an induction and underwent a probation period during which time they were more closely monitored and supported. We looked at the records of a new staff member's recent probationary' meeting. The meeting covered all aspects of the new employee's role and had agreed actions in place. All staff had a regular supervision. One staff member told us, "The meetings with my manager are pretty regular; I get the chance to talk about anything that is relevant, like training." All staff told us they felt well supported in their roles and could approach senior staff if they needed advice.

During the inspection we heard staff asking people for their consent and agreement to care. For example we heard the staff say, "Here are your tablets, are you ready to take them?" and "Can I help you to the bathroom." Staff had knowledge of the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS). The Mental Capacity Act 2005 sets out how to support people who do not have capacity to make a specific decision. Policies and procedures were available for staff on the MCA and DoLS.

Requires improvement

Is the service effective?

These provided staff with guidance regarding their roles and responsibilities under the legislation. Staff understood the principles of the MCA and respected people's rights, where they had capacity, to make 'unwise' decisions (decision that may place them at risk). One staff member told us, "I always try my best to support residents to make their own decisions." On the day of our inspection, three people were subject to a DoLS authorisation. The registered manager was clear on how to process an application and told us there were other applications pending with the managing authority.

We saw people had been referred to a range of health care professionals, these included continence nurses, district nurses and Speech and Language Therapists (SALT). People had access to routine appointments with chiropodists and opticians. One person told us, "I see my Doctor when I need to; the staff always sort this out for me quickly." We spoke with one visiting health care professional during the Inspection. They were positive about the home and the staffs' responsiveness. They said, "Staff here are welcoming and receptive to any feedback."

We observed senior staff handover between shifts. Staff were provided with a clear overview of how people had spent their time, their mood and any specific health concerns. For example identifying a person had seen their district nurse and another person seemed much more sleepy than usual. Senior staff used the hand over to brief the team they would be working with and allocated duties accordingly.

Requires improvement

Is the service caring?

Our findings

Although people and their relatives spoke highly of the service and the caring nature of staff we found the service was not consistently caring.

Peoples' confidentially and dignity was not always seen to be protected. On the first day of our inspection we saw the area on the ground floor used by staff for completing paperwork had one person's care plan left unattended and a handover sheet which identified what personal care people had received, for example who had been to the toilet. A person's relative was present for a section of the staff handover on the ground floor on the first day of the inspection. Personal information was being shared amongst staff that was not suitable to be overheard by this relative.

We found communal bathrooms on the first floor contained items which did not promote people's dignity. For example one communal bathroom had a person's underwear hanging on a rail. Another had a cushion from one of the lounges that had a sign on stating, 'needs cleaning'. A communal toilet had a notice on the wall for staff to remind them not to 'flush wipes or pads'. These examples demonstrated a lack of sensitivity to communal living.

On the ground floor during the lunch service on the first day of our inspection a staff member brought two plated lunch options to a person to enable them to make a visual choice. The person chose one option but said they didn't like beans, which were on the plate. The staff member told them to 'just leave, anything you don't like.' The member of staff did not offer to change the plate for the person. This meant this person's choice had not been respected. People who are living with dementia may have difficulties communicating their preferences.

The above issues related to confidentially and dignity requires improvement.

However, we also observed much positive, caring and kind interaction between people and staff. Staff were knowledgeable about individual personalities of people they supported. Staff shared people's personalities with us during the inspection and they talked of people with respect and affection. One care staff member said, "The residents are what it's all about for me, they always come first." We over heard a member of care staff calling a hospital ward to check on the welfare of a person. We observed occasions when staff were supporting people; they worked at the person's own pace and did not rush them. Staff were seen chatting and demonstrated light heartedness with people whilst providing support. One person said, "They are first class, really lovely caring people." We observed a member of care staff supporting one person to dry their hair, the person was holding a photograph of their family and the staff member was chatting to them about their family. They had created a calm, relaxing and enjoyable environment for the person who appeared content with the staff member's support.

All bedrooms were single occupancy and they had been personalised with people's own belongings including furniture, photographs and ornaments. 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 prior to entering. People told us, "I get privacy when they (staff) help me" and "They knock on my door even though I like usually like it open."

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 a lot of their doing 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.

People were supported to maintain their personal and physical appearance in accordance with their own wishes. People were dressed in clothes they preferred and in the way they wanted. Women were seen wearing their jewellery and people's hair was neatly done. One person told us, "They (care staff) help me to choose what to wear, they are ever so good." Another said, "The hair dresser comes today, they (the staff) always comment on how lovely it looks after."

Requires improvement

Is the service responsive?

Our findings

Although people told us they were happy with the care they received we found the service was not consistently responsive to people's needs.

The registered manager told us the service operated a keyworker system. A keyworker is a named member of care staff who works more closely with a person and will have specific additional responsibilities, for example ensuring the person has appropriate clothing and toiletries and liaising with a person's family. Although some people told us they had a keyworker others had not been allocated one. The registered manager was unable to identify which people did or did not have a key worker. There was no clear guidance for staff as to what were their responsibilities in relation to this aspect of their role. One member of care staff told us they did not know if they were a keyworker to anyone. This meant some people may have been receiving additional support from staff that others were not. The registered manager told us due to recent high staff turnover this was an area that required attention.

The provider employed an activities co-ordinator who worked Monday to Friday between 9-5. They told us when they arrived in the morning they supported the care staff with breakfast and would usually begin their 'activities role' from 'about 10.30'. They produced a weekly timetable which was displayed in various places around the home. We saw there were periods of the day when people were sat in lounges for extended periods and received limited interaction from staff. At these times care staff were undertaking their support duties and the activities co-ordinator was split across two floors facilitating activities for up to 53 people. At the weekends care staff were responsible for activities, the activities co-ordinator left suggestions and ideas for care staff. People we spoke with told us weekends were usually quieter. One person said, "I do notice the difference at weekends, can be quiet and not much going on." We spoke to the registered manager and area manager about this issue and they stated they would review staffing hours in the light of our feedback. This is an area that requires improvement.

However at other times we saw people enjoying positive interaction in both small group activities such as arts and crafts and one to one. We saw people being encouraged to become involved in assisting with domestic tasks such as folding socks and light cleaning. One person told us they enjoyed the visiting entertainer. The activities co-coordinator told us they were able to book two external visiting events a month, these included 'pet therapy' and musical entertainers. The home was affiliated with a nearby Church and the minister was contracted to be at Richmond for 15 hours a week. We saw they were very much included in all parts of the service. They were chatting to be people and staff and knew people well. One person had received some distressing news and the minister was requested by the registered manager to be present when they were communicating this. People told us they liked the home's close connection with the Church. The midweek Church service held in one of the ground floor rooms was well attended. One person played the piano. One person said, "The place has a strong community feel to it when we come together for the service."

The home had gardens which people told us they enjoyed using in the warmer months. During our inspection we saw four people sitting in a dedicated 'movie area' watching a film. We saw people had been involved in choosing and influencing how the environment looked and how the service ran. For example we saw the ground floor dining area had undergone a recent redecoration. The area resembled a '50's diner' which had been chosen by people as had the themes for corridors, one of which was a sea side prom. The registered manager told us how they had recently changed the way meal times work in response to people's feedback. The main meal was now served in the early evening as opposed to lunch time. They said, "This change came about in light of feedback from residents and staff, we found residents who may go out over the lunch time would miss the main meal." People told us they liked this change and that it meant they were not 'as sleepy' after a 'big lunch.'

People and their relatives told us they had been involved in the design of their care plans. One relative told us they knew of a care plan and had contributed to it. One person said, "I have been asked and involved in my care." Prior to 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

Requires improvement

Is the service responsive?

could see how people were feeling and what they had eaten and drunk. Care plans contained 'life stories' which captured information on people's background, interests and likes and dislikes.

The PIR identified 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. We saw there had been one recent complaint received which had been responded to in a timely manner, in line with the provider's policy, and the complainant was satisfied with the response and the complaint closed.

Requires improvement

Is the service well-led?

Our findings

People, their relatives and staff spoke highly of the registered manager and the senior staff. However we found the service was not consistently well led.

The PIR identified that regular audits and quality assurance systems were undertaken. However we found the data collected had not been consistently analysed to provide the registered manager with an insight into some of the concerns we identified during our inspection. For example, although a falls audit was being completed on a monthly basis the most recent one had not recognised over half the falls had occurred during the timeslot where we had identified staffing levels as a concern.

The registered manager had been in post for close to 12 months during this time they had identified people's care documentation required improvement. They had introduced a system to systematically quality check all care plans. We found this had been effective at improving the quality of those care plans that had been checked. However during the 12 months not all care plans had received this quality check. We found not all care plans were up-to-date and reflected people's current care needs. For example we found one person had recently returned from an extended stay in hospital during which time their support needs had changed significantly. From speaking to the person and staff it was evident a detailed verbal re-assessment had occurred prior to them coming back to the service however their care documentation did not reflect the changes in their support needs. The registered manager told us there was currently no documentation routinely used to capture people's reassessment prior to returning to the service following a hospital admission.

Some daily records were not accurately capturing what care had been delivered and by who. For example on the first day of the inspection records on the ground floor identified only one person had a shower or bath in the 27 days of January. People and staff told us this was not accurate however records indicated all other people had only had a wash. These same records identified one staff member had delivered all personal care.

People told us 'resident meetings' took place where they could discuss any issues related to their lives at Richmond. However we were unable to evidence the content of these meetings as the registered manager was unable to locate any recent meeting minutes. The above issues related to quality assurance and records require improvement.

We found other quality assurance systems under taken by the provider's area manager and the registered manager were effective at identifying and driving improvement within the service. For example the area manager's monthly visit and report routinely scrutinised a wide of range of aspects the service such as maintenance and staff files. Where action points had been recommended there was a clear time scale attached. The registered manager told us they found these visits helpful and constructive.

The registered manager told us they felt supported by their line manager and communication between themselves and head office was effective. During our inspection we heard the registered manager and their deputy liaising with the providers administration 'head office' function by telephone. The registered manager said, "If I need something I feel confident I will be supported." They described recent training and support events they had been involved with. For example, external regional registered manager meetings. Staff we spoke to were positive about their roles and the people they supported. We noted that the provider ran a 'staff forum' whereby a staff representative from Richmond attended meetings to share the collective views of the staff at their service with other colleagues and senior staff from other services.

The PIR identified the registered manager regularly liaised with another registered manager from one of the providers other nearby services. These were referred to as 'co-buddy' visits. On the first day of our inspection we saw one of these was taking place. The registered manager told us this was a good opportunity to share good practice and discuss current issues in both services.

There was a clear management structure at Richmond. Staff members were aware of the line of accountability and who to contact in the event of any emergency or concerns. The registered manager was visible to people and staff. Staff commented that the registered manager and their deputy were available for advice. Staff told us they were supported within their roles and described an 'open door' management approach. People and staff commented that the overarching ethos of Faith within the home was an important aspect to making the home a caring environment. Staff were encouraged to ask questions,

Requires improvement

Is the service well-led?

discuss suggestions and address concerns with management. One member of staff told us, “Management is approachable; you can always pop in the office.” Staff meetings were held regularly and were well attended. We saw recent the meeting minutes from a night staff meeting, these identified staff had requested a senior carer was on at night which had been actioned.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment **The provider had failed to ensure all areas of the premises were secure. Reg 15 (1)(b)**