Inspection Report

We are the regulator: *Our job is to check whether hospitals, care homes and care services are meeting essential standards.*

Ryecroft Private Residential Care Home

1 Kings Avenue, Meols, Wirral, CH47 0NH

Tel: 01516321068

Date of Inspection: 11 December 2014

Date of Publication: February 2015

We inspected the following standards in response to concerns that standards weren't being met. This is what we found:

Care and welfare of people who use services	✖	Enforcement action taken
Management of medicines	✖	Enforcement action taken
Requirements relating to workers	✖	Enforcement action taken

Details about this location

Registered Provider	Ryecroft Care Limited
Registered Manager	Miss Eileen Mountford
Overview of the service	Ryecroft Private Residential Home is registered to provide personal care to a maximum of 14 people. The home is located in Meols, Wirral and is close to local amenities. Twelve of the home's bedrooms are ensuite and bedroom accommodation is located across three floors accessible by a passenger lift.
Type of service	Care home service without nursing
Regulated activity	Accommodation for persons who require nursing or personal care

Contents

When you read this report, you may find it useful to read the sections towards the back called 'About CQC inspections' and 'How we define our judgements'.

Summary of this inspection

Why we carried out this inspection

We carried out this inspection in response to concerns that one or more of the essential standards of quality and safety were not being met.

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 11 December 2014, observed how people were being cared for and talked with people who use the service. We talked with staff and talked with commissioners of services.

What people told us and what we found

This inspection was conducted in response to concerns raised with us by the Local Authority in relation to medicine management and the staff recruitment practices operated at the home. We used this information to plan our visit.

At the time of our inspection, a manager was employed at the home who was not registered with the Care Quality Commission. This meant that the manager's fitness to be the registered manager had not been assessed by the Care Quality Commission.

A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.'

The inspection team who carried out this inspection consisted of an adult social care inspection manager and an adult social care inspector. During the inspection, the team worked together to answer five key questions; is the service safe, effective, caring, responsive and well-led?

As part of this inspection we spoke with two people who used the service, the provider, the manager, a team leader, two care staff and the Local Authority. We also reviewed records relating to the management of the home which included three care records, a sample of medication records and six staff files. Below is a summary of what we found. The summary describes what people using the service, the provider and the staff told us, what we observed and the records we looked at.

Is the service safe?
The service was not safe. We looked at six staff files. We found that appropriate checks in relation to the safety and suitability of staff to work with vulnerable people had not been made prior to their employment.

We looked at the three people's care records and found they contained insufficient information about people's needs. Care was not adequately planned or risks properly

identified and managed. This placed people at risk of receiving inappropriate and unsafe care that did not meet their needs.

Staff we spoke with shared their concerns about the care they were providing to one person who lived at the home. We reviewed this person's care. We found that the person's care had not been planned and the care provided was unsafe. For example, the provider did not have any moving and handling equipment in place to enable staff to safely meet the person's mobility needs. This placed both the person and staff at risk of serious harm.

Medicines were poorly managed. Some people did not receive their medication when they needed them and some people did not receive some of their medication for significant periods. We observed a medication round in progress. The administration of medication was disorganised and unsafe. Staff records showed that all staff training in medicine administration was out of date. Records relating to the administration of medication were poor and inaccurate and medicines were not always stored securely. This meant people's health and wellbeing was placed at serious risk.

Is the service effective?
The service was not effective. We found care plans did not provide sufficient detail to ensure people's needs were met. Risks to people were increased as staff were provided with little information about what people's risks were, how to manage them and how to respond to the risk should it occur.

For example, one person had dementia and sometimes displayed behaviour that posed a risk to themselves and others. The person's care plan however failed to identify and provide any guidance to staff on how to support the person with dementia effectively so that they were able to communicate their needs and wishes. The risk management tools recommended by the person's social worker had also not been used consistently to effectively monitor and safely manage any unwanted behaviours.

Is the service caring?
The service was not always caring. We observed staff supporting people throughout the day and noted they spoke pleasantly and treated people kindly and with respect.

We found however that people's social and emotional needs were not always considered in the planning and delivery of care. For example, one person at the home was immobile. We visited the person and saw that they were sat in their bedroom with no television or radio and no means of accessing the communal areas downstairs for company. The person told us "I don't want to be here".

Is the service responsive?
The service was not responsive. People's individual needs were not consistently met. For example, one person at the home was unwell and had not received their newly prescribed medication in a timely manner. We asked the team leader about this, who confirmed the medication had not yet been obtained. Two other people at the home had also not received all of their required medication as the home had run out of stock. This demonstrated that people's health and welfare needs were not responded to appropriately or in a timely manner.

Is the service well led?
The service was not well led. The provider did not have effective systems in place to ensure that people's needs and care were assessed, planned and delivered appropriately

and in a safe manner. There were no robust procedures in place to ensure that staff employed were suitable for their job roles and the provider did not have appropriate arrangements in place to protect people from the unsafe use and management of medications.

We found that the provider had failed to provide satisfactory management and leadership in the delivery of the service which placed people at serious risk.

We had major concerns about the service during our visit. We discussed these with the new manager in post and the provider. We also made two safeguarding referrals to the Local Authority in relation to two people's medication issues.

You can see our judgements on the front page of this report.

What we have told the provider to do

We have referred our findings to Local Authority: Commissioning and Local Authority: Safeguarding. We will check to make sure that action is taken to meet the essential standards.

We have taken enforcement action against Ryecroft Private Residential Care Home to protect the health, safety and welfare of people using this service.

Where providers are not meeting essential standards, we have a range of enforcement powers we can use to protect the health, safety and welfare of people who use this service (and others, where appropriate). When we propose to take enforcement action, our decision is open to challenge by the provider through a variety of internal and external appeal processes. We will publish a further report on any action we take.

More information about the provider

Please see our website www.cqc.org.uk for more information, including our most recent judgements against the essential standards. You can contact us using the telephone number on the back of the report if you have additional questions.

There is a glossary at the back of this report which has definitions for words and phrases we use in the report.

Our judgements for each standard inspected

Care and welfare of people who use services ✖ Enforcement action taken

People should get safe and appropriate care that meets their needs and supports their rights

Our judgement

The provider was not meeting this standard.

Care and treatment was not planned and delivered in a way that was intended to ensure people's safety and welfare.

We have judged that this has a major impact on people who use the service and have taken enforcement action against this provider. Please see the 'Enforcement action' section within this report.

Reasons for our judgement

We included this outcome area in our inspection, on the day of our inspection, as we had serious concerns about the quality and safety of the care provided to people who lived at the home. At the time of our visit, there were 14 people who lived at the home. A new manager had commenced in employment four days prior to our visit. This manager is not yet registered with the Care Quality Commission.

We spoke with two people who lived at the home, the three staff members, the new manager in post and the provider during our visit.

Staff we spoke with raised concerns with us, about the safety of the care that they were providing to one person at the home. We were told that the person had mobility problems but that the home had no moving and handling equipment to move the person safely. They said as a result they had to manually lift the person from the bed to the chair. One staff member told us that two staff had already "gone off work with bad backs". This meant that the person had received inappropriate and unsafe care which placed both them and staff at significant risk of injury.

We spoke to the person concerned who told us "The people here are nice but they haven't got the stuff to help me. I don't want to be here. I can't walk and haven't got a wheelchair here. The staff lift me out of bed and into the chair. I get very frustrated; it's hard on the staff". We noted that the person was sat in a chair in their bedroom with no television, no radio and no means of accessing communal areas for company.

We looked at this person's care records and found it contained little assessment information about the person's needs and risks. It also contained no information relating to

the person's care as care plans and risks assessment were not completed. This meant staff had no guidance on what the person's needs, risks and preferences were in the delivery of care.

We saw that a nurse had visited the person during November 2014 and documented concerns about the risks to both the person's and staff health and safety. The nurse had documented that the manager would review the person's care. One staff member we spoke with told us staff had raised concerns about the care of the person with "Everyone we can".

We spoke to the provider about this. They told us that they had notified the Local Authority of the difficulties in caring for the person. We saw no evidence however in the person's care file to demonstrate that any action had been taken. After our visit, we discussed our concerns with the Local Authority who had already raised a safeguarding alert in relation to this person after a recent Local Authority visit to the home.

We looked at two other care files as a result of our observations of care. These care files also contained limited, disjointed and conflicting information about people's needs, risks and care.

For example, one person's continence care plan described them as incontinent and requiring incontinence pads whereas the person's risk assessment described them as continent. There was no guidance to staff on the type of incontinence, the incontinence pad to be used and the person's preferences in relation to this type of personal care. The care plan simply stated "keep track of stock and re-order".

We spoke with a person who lived at the home who we saw had not received their prescribed medication for an illness in a timely way. We spoke to the provider about this who acknowledged that the treatment prescribed by the doctor had not yet been obtained. This meant the provider had failed to meet the person's individual needs which placed their health and welfare at risk. We asked the provider to obtain this medication without delay.

One person care file indicated that they had had multiple falls since April 2014. The person's mobility care plan however made no reference to the person's history of falls, the significant risk of further falls and offered no risk management guidelines to staff on how to prevent a fall. This placed the person at significant risk of further falls occurring.

The person care file also stated the person had dementia and was "experiencing occasions where their behaviour can cause distress to themselves and other". There was no dementia care plan in place however to advise staff on how best to support and communicate with the person or any risk management plans in place to guide staff on how to respond appropriately to any behaviours that challenge. This placed the person at serious risk of inappropriate and unsafe care.

We discussed our concerns in relation to the quality and safety of the care provided at the home with the Local Authority.

Management of medicines ✖ Enforcement action taken

People should be given the medicines they need when they need them, and in a safe way

Our judgement

The provider was not meeting this standard.

People were not protected against the risks associated with medicines because the provider did not have appropriate arrangements in place to manage medicines.

We have judged that this has a major impact on people who use the service and have taken enforcement action against this provider. Please see the 'Enforcement action' section within this report.

Reasons for our judgement

Prior to our visit, the Local Authority had raised concerns with us about the way in which medicines were managed and administered at the home. We used this information to plan our visit. On the day of the inspection, we found that medication was not stored, administered or managed in a safe way.

Most medicines in current use were kept in a locked trolley however the trolley was not secured to the wall. During the morning medication round, we observed that medication was left unattended on the dining room table and we also found a variety of prescribed creams and inhaler medication stored in people's bedrooms. This meant medication was not always stored securely, leaving the medicines accessible to unauthorised staff, visitors and people living in the home.

We saw that one person's prescribed creams and medications were stored in a box on top of a radiator shelf. A thermometer in the box indicated the medicines were stored at 30 centigrade. The majority of medicines should be stored at temperatures no greater than 25 centigrade. This meant there was a risk that the medication may not have been safe to use or may have lost its effectiveness.

In one person's bedroom we found four dispensers of prescribed creams and two different types of prescribed inhaler medication. We looked at this person's care file and saw that they were identified as having dementia. The Mental Capacity Act 2005 requires all those working with people who potentially lack capacity to continually assess the person's capacity to make a particular decision or judgement at any given time. We saw that no assessment of the person's understanding of and capacity to self administer their medication safely had been assessed. There had also been no assessment of the risks. This placed the person's health, welfare and safety at considerable risk.

We observed a medication round being undertaken by the manager and the team leader.

We saw that they were both constantly interrupted. For example, we saw that the administration of medication to one person in their bedroom was undertaken by the manager shortly after 10 am. The manager was interrupted by the team leader who then took over the administration of the medication and the manager left the person's bedroom. The team leader was then interrupted by the provider and two care staff who wanted to support the person to get dressed. Constant interruptions and distractions increase the risk of medication mistakes being made that may cause unnecessary harm to people.

Interruptions during the medication round also meant the majority of people experienced substantial delays in receiving their medication at the right time. For example, some people whose medication was due to be administered at 9am did not receive their medication till after midday. This meant people were not given the medicines that were important to their health and wellbeing when they needed them and in a safe way.

We checked a sample of people's medication administration charts (MARs) and found discrepancies in all four charts. For example, some medication was signed for as administered but the medication was still in the person's blister pack and some medication had not been signed for, but was missing. This meant that medication records relating to the safe administration of medication had not been correctly completed and some medications were unaccounted for.

On checking people's MAR charts we also saw that two other people in December 2014 had not received some of their prescribed medication for over seven days due to insufficient stock at the home. We raised this with the provider but were given no satisfactory explanation as to why this medication was not sourced appropriately. People are at serious risk of harm when they do not receive their medication as prescribed.

We reviewed records relating to staff medication training. We saw that staff training was out of date. This meant that staff who were administering medication had not had their skills updated. On the day of our visit, this training has been arranged and was in progress.

Requirements relating to workers ✖ Enforcement action taken

People should be cared for by staff who are properly qualified and able to do their job

Our judgement

The provider was not meeting this standard.

The provider did not have effective recruitment procedures in place to ensure people who worked at the home were of good character and suitable to work with vulnerable people.

We have judged that this has a major impact on people who use the service and have taken enforcement action against this provider. Please see the 'Enforcement action' section within this report.

Reasons for our judgement

Prior to our visit, the Local Authority had raised concerns with us about the way in which the provider recruited and selected staff. We used this information to plan our inspection.

During this inspection we looked at the staff records of six staff who, had recently been recruited. The regulation requires that the provider obtains an enhanced criminal record certificate. This is known as a Disclosure and Barring Service (DBS) check. Information about a criminal record or other restrictions helps employers make safer recruitment decisions and helps to prevent unsuitable people from working with vulnerable groups.

We saw that in four instances staff had been allowed to work before the completed DBS check had been received. We asked the provider about this and they told us that one staff member had been working only under supervision prior to the DBS check being received. We saw evidence that this staff member had conducted a pre assessment visit for a prospective service user. We asked the provider and they told us that this person had not been supervised whilst undertaking this task.

We asked if there was evidence to support people working under supervision prior to the DBS checks being received. The provider told us that they did not have any. They had not undertaken any risk assessments or put any plans in place to mitigate the risks for employing staff who had not had the appropriate checks carried out.

We spoke with a staff member who told us that they had been working at the home for the previous two months. We saw that their DBS check had not been received until three weeks after the date they commenced employment.

The provider is also required to obtain suitable references prior to staff commencing work. We saw for two staff members that the appropriate references had not been obtained. Neither staff file contained a reference from their previous employer.

We saw that one person had been recruited into a senior management position in the home. There was no evidence in their staff file that this person had completed an application form, had taken part in an interview or had a DBS check applied for. We were told that this person had been dismissed two weeks after they commenced employment because they were unsuitable. We did not see any evidence to demonstrate that this person had been recruited safely.

This section is primarily information for the provider

✖ Enforcement action we have taken to protect the health, safety and welfare of people using this service

Enforcement actions we have taken

The table below shows enforcement action we have taken because the provider was not meeting the essential standards of quality and safety (or parts of the standards) as shown below.

We have served a warning notice to be met by 27 February 2015 This action has been taken in relation to:	
Regulated activity	Regulation or section of the Act
Accommodation for persons who require nursing or personal care	**Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010** **Care and welfare of people who use services**
	How the regulation was not being met: The provider had not taken proper steps to ensure that people were protected against the risks of receiving unsafe or inappropriate care as the planning and delivery of care did not meet people's individual needs or ensure their welfare and safety. Regulation 9(1)(b)(i) and (ii).
We have served a warning notice to be met by 27 February 2015 This action has been taken in relation to:	
Regulated activity	Regulation or section of the Act
Accommodation for persons who require nursing or personal care	**Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010** **Management of medicines**
	How the regulation was not being met: Service users were not protected against the risks associated with unsafe use and management of medicines as the provider did not have appropriate arrangements in place for the recording,

This section is primarily information for the provider

	handling, safe keeping, dispensing, safe administration and disposal of medicines at the home. Regulation 13
We have served a warning notice to be met by 27 February 2015 This action has been taken in relation to:	
Regulated activity	Regulation or section of the Act
Accommodation for persons who require nursing or personal care	**Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010** **Requirements relating to workers**
	How the regulation was not being met: The provider did not have effective recruitment procedures in place that ensured people who worked at the home were of good character and suitable to work with vulnerable people. Regulation 21(a)(i).

For more information about the enforcement action we can take, please see our *Enforcement policy* on our website.

About CQC inspections

We are the regulator of health and social care in England.

All providers of regulated health and social care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as "government standards".

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of other services less often. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service's records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.

How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

✓ **Met this standard**	This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.
✖ **Action needed**	This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.
✖ **Enforcement action taken**	If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.

How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. Only where there is non compliance with one or more of Regulations 9-24 of the Regulated Activity Regulations, will our report include a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation). This could be a minor, moderate or major impact.

Minor impact - people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

Moderate impact - people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

Major impact - people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.

Glossary of terms we use in this report

Essential standard

The essential standards of quality and safety are described in our *Guidance about compliance: Essential standards of quality and safety*. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the *Guidance about compliance*. The 16 essential standards are:

Respecting and involving people who use services - Outcome 1 (Regulation 17)
Consent to care and treatment - Outcome 2 (Regulation 18)
Care and welfare of people who use services - Outcome 4 (Regulation 9)
Meeting Nutritional Needs - Outcome 5 (Regulation 14)
Cooperating with other providers - Outcome 6 (Regulation 24)
Safeguarding people who use services from abuse - Outcome 7 (Regulation 11)
Cleanliness and infection control - Outcome 8 (Regulation 12)
Management of medicines - Outcome 9 (Regulation 13)
Safety and suitability of premises - Outcome 10 (Regulation 15)
Safety, availability and suitability of equipment - Outcome 11 (Regulation 16)
Requirements relating to workers - Outcome 12 (Regulation 21)
Staffing - Outcome 13 (Regulation 22)
Supporting Staff - Outcome 14 (Regulation 23)
Assessing and monitoring the quality of service provision - Outcome 16 (Regulation 10)
Complaints - Outcome 17 (Regulation 19)
Records - Outcome 21 (Regulation 20)

Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.

Glossary of terms we use in this report (continued)

(Registered) Provider

There are several legal terms relating to the providers of services. These include registered person, service provider and registered manager. The term 'provider' means anyone with a legal responsibility for ensuring that the requirements of the law are carried out. On our website we often refer to providers as a 'service'.

Regulations

We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

Responsive inspection

This is carried out at any time in relation to identified concerns.

Routine inspection

This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.

Themed inspection

This is targeted to look at specific standards, sectors or types of care.

Contact us

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