Denmax Limited

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

Summary of findings

Overall summary

This inspection was carried out over three days on the 19, 20 and 21 September 2016. Our visit on 19 September 2016 was unannounced.

We last inspected Richard House Care Home on 11 December 2013. At that inspection we found the service was meeting the regulations we assessed.

Richard House Care Home is located in the Cale Green area of Stockport and offers accommodation to 29 people who require assistance with personal care and support.

Accommodation is provided on two floors, which are accessible by a passenger lift. There are twenty five bedrooms four of which have the capacity to be used as shared rooms. However at the time of this inspection all of the rooms occupied were single occupancy. Six bedrooms have en-suite faculties.

The home has three lounges, a sun room and two dining rooms as well as parking and outside garden space to the rear of the property.

On the first day of our inspection twenty two people were living at the home, however one person was later discharged home so twenty one people were accommodated at the home for the remainder of the inspection.

A Registered Manager was in post although they were not available during this inspection as they were on annual leave. 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.

During this inspection we identified six breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Full information about Care Quality Commission's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

Some medicines were not managed safely. We found there were not always clear, detailed written directions for the use of medicines to enable staff to apply topical prescribed creams for example doublebase cream and fenbid gel as intended by the person's doctor. This meant there was a risk that prescribed creams may not have been applied when required, which could have resulted in unnecessary discomfort for the person.

We had concerns in relation to staff supervision because staff were not receiving supervision on a regular, ongoing basis. This meant that staff were not being appropriately guided and supported to fulfil their job

role effectively.

Some of the routine safety checks had not been undertaken, for example, checks of window restrictors, water temperature delivery testing and the nurse call system. This meant the provider could not be sure people using the service were supported to remain as safe as possible at all times.

Recruitment processes required improvements to ensure only suitable staff were employed to work with vulnerable people.

We saw that some people's identified care needs did not have a corresponding plan of care to direct care staff on how to meet the person's individual care need, for example, the use of topical creams or if a person had a chest or urine infection. This meant there was risk that people could receive unsafe and inappropriate care.

Staff training records viewed indicated there were gaps in staff training. This meant some staff were not being appropriately trained and skilled to meet the needs of the people living at the home.

We found that robust systems had not been implemented to monitor the quality and safety of service people received.

People were supported by a stable staff team who had worked together for a number of years and knew the people living at Richard House very well. However we found there was not a systematic approach to determine the number of staff and range of skills required to meet the needs of the people who used the service. This meant the registered provider could not be sure that the staffing levels and skill mix of staff were sufficient to meet the assessed needs of people living at Richard House Care Home. We made a recommendation that they implement the use of a staffing tool.

We recommended that the service considers reviewing people's plans of care to ensure where possible they are developed in partnership with the person using the service and are designed to meet their specific individual needs and personal preferences.

We recommended that the service further develops the pre admission assessment form to ensure they can fully meet all of the person's individual care needs.

We recommended that individual assessments of people's hobbies and interests were undertaken and recorded to ensure that the activities provided were in accordance with people's personal preferences.

The visitors we spoke with told us they thought Richard House Care Home was a homely, friendly care home and they were happy their relative was well looked after.

There was a complaint notice on display in the main entrance hall of the home although we found the complaint policy to be out of date and there was not a clear system in place for receiving, handling and responding to concerns and complaints.

Staff spoken with understood the need to obtain verbal consent from people using the service before a task or care was undertaken and staff were seen to obtain consent prior to providing care or support.

From our observations of staff interactions and conversation with people we saw staff had good relationships with the people they were caring for and the atmosphere felt friendly and relaxed.

Attention was paid to people's diet and people were supported to eat and drink in a way that met their needs. All of the people living at Richard house Care Home who we spoke with were full of praise for the cook and the meals provided. We were told that the food was all homemade, very tasty and there was more than enough food and drink provided.

The healthcare professional we spoke with told us they had no concerns for the people living at Richard House Care Home and they told us they thought the staff were exceptional and very caring.

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 safe

Medicines administration records for prescribed creams lacked detailed instructions and were unclear.

We found that the registered provider had not done all that was reasonably practicable to mitigate risk to people.

Appropriate checks had not been undertaken to ensure suitable staff were employed to work with vulnerable people.

Is the service effective?

Requires Improvement

The service was not always effective

Not all staff had received regular, on-going supervision.

Not all staff had undertaken training or updates as required which meant people were at risk of receiving unsafe and inappropriate care.

People could make choices about their food and drink.

Is the service caring?

Good

The service was caring

Staff were seen to be kind and caring in their interactions with people.

People looked content and well cared for.

Visitors spoken with told us they thought their loved ones were well cared for.

Is the service responsive?

Requires Improvement

The service was not always responsive

There was not a clear system in place for receiving, handling and responding to concerns and complaints.

People told us the care staff responded promptly to their needs.

Is the service well-led?

Inadequate

The service was not well led

The service had a manager registered with the Care Quality Commission (CQC).

The systems in place to monitor the quality and safety of service provision were not effective and failed to identify the issues and concerns we found during our inspection.

Some policies and procedures made reference to the previous regulating body.

Richard House Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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.

This inspection was carried out over three days on the 19, 20 and 21 September 2016. Our visit on 19 September 2016 was unannounced. The inspection team consisted of one adult social care inspector.

Before the inspection we reviewed the previous Care Quality Commission (CQC) inspection report about the service and notifications of incidents that we had received from the service. We looked at the Provider Information Return (PIR) before our visit. A PIR is a document that asks the provider to give us some key information about the service, what the service does well and any improvements they plan to make.

We also contacted the local authority commissioners, Stockport Metropolitan Borough Council (MBC) Health Protection and Control of Infection Unit and Healthwatch, Stockport. Healthwatch Stockport is an independent organisation, working to help people have their say on local health & social care services to seek their views about the home. We did not receive any information of concern.

During our visits we spoke with three senior carer's who were in day to day control of the home while the registered manager was on annual leave, we also spoke with two care workers, the laundry assistant, the cook, two visitors to the home, a visiting General Practitioner and five people living at Richard House Care Home.

We looked around the building including a sample of bedrooms on both floors, all of the communal areas, toilets, bathrooms, the kitchen and the garden.

We examined the care records for four people living in Richard House Care Home, medicine administration records, the recruitment and supervision records for four staff, training records and records relating to the management of the home such as the quality assurances systems. We also looked at four staff personnel files.

Requires Improvement

Is the service safe?

Our findings

We looked at the systems in place for the management of medicines and reviewed policies and procedures in place relating to the administration of medicines.

One of the senior carer's who undertook this inspection with us in the absence of the registered manager told us that care staff were not allowed to administer medication until they had received the appropriate training. We were told that out of the seventeen care staff employed, six care staff and the registered manager administered medication. The training record indicated that four members of staff and the registered manager required refresher training.

We looked at two records where Fenbid gel had been prescribed. There were no clear, detailed written directions for their use to enable staff to apply the creams as intended by the person's doctor. We looked in the care files for these two people and found there were no plans of care in place in relation to the use of these creams.

We saw large gaps in the recording on the 'topical administration record chart' of double base cream being applied for one person. For the whole of May 2016 it had only been recorded as being applied on six occasions and once in June 2016.

This meant there was a risk that people may not have received prescribed creams as intended by their doctor, which could result in unnecessary discomfort for the person.

The home operated a Monitored Dosage System (MDS). This is a system where the dispensing pharmacist places medicines into a cassette containing separate compartments according to the time of day the medication is prescribed. We carried out a tablet count for five individually boxed medications and therefore were not included in the MDS system. We found in two instances there were discrepancies. We found in one instance that a prescribed supplement was missing and unaccounted for and in another instance there were four tablets too many. This meant there was a risk that the two people these tablets had been prescribed for may not have received their medications as prescribed by their doctor and could put them at risk of harm.

We saw a monthly medication audit was being undertaken; however it did not include checking the boxed medication that should have been administered as prescribed by the person's doctor.

We looked at two bottles of eye drops that had a limited life span of 28 days. We saw that both bottles were in use but only one had a recorded date of opening. This meant there was a risk that the medication without the date of opening being recorded could be administered beyond its expiry date. This was raised with the senior carer on duty who said the date of opening is usually recorded and they were unsure why in this instance it had not been recorded. The possible effects of using expired stock are the medication could become chemically unstable. The effectiveness of the drug may change; the break down products of the drug may become toxic and harmful to the person increasing risk of contamination.

The above examples demonstrate a breach of regulation 12 (1) (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Medication was stored in a locked trolley secured to the wall in one of the dining rooms.

At the time of our inspection we were told that no person using the service was administering their own medications, receiving controlled drugs or was receiving their medicines in a covert way. Covert medication is the administration of any medical treatment in a disguised form. This usually involves disguising medication for example by administering it in food and drink. As a result, the person is unknowingly taking medication. On reviewing the Covert Medication policy we found it made reference to the outdated National Minimum Standards for Care Homes for Older People.

We recommend that the service reviews this policy in order to ensure that it is reflective of current best practice in this area.

During our inspection we looked around the home, we looked at all the communal areas, toilets, bathrooms, the kitchen and a sample of bedrooms on both floors.

We saw there was a cleanliness and infection control policy, however it was last updated in May 2014 and made reference to the outdated National Minimum Standards for Care Homes for Older People. This meant staff were not provided with up to date information that reflected current legislation.

We saw that although the home was clean there was no evidence that the service undertook any formal, internal infection control audits or checks to ensure a high standard of cleanliness was being maintained. We saw that some of the wheelchairs were dirty and there was no record of wheelchairs being cleaned. The senior carer assured us they would be thoroughly cleaned and following the third day of the inspection we received email confirmation that a wheelchair cleaning record had been implemented. The cleaning schedules in place, excluding the kitchen cleaning schedules which were detailed and fully completed, were vague and did not evidence exactly what had been cleaned and when. For example there was a daily tick box record of bedroom cleaning which had not been completed daily, it was not clear how often the lounges were to be cleaned, there was no evidence of toilet and bathroom cleaning and the senior carer told us the night staff undertook cleaning duties which were not recorded.

We saw that Stockport Metropolitan Borough Council Health Protection and Control of Infection Unit had undertaken a recent audit in March 2016 and no major issues were identified.

We saw that much of the paintwork throughout the home was chipped and worn and corridor carpets were well worn.

During the inspection there was no evidence of planned maintenance work or evidence of maintenance work that had been undertaken, although we did see the home employed the services of a maintenance person. We found that there was no refurbishment or redecoration plan in place although we were sent one following day three of the inspection. A preventive maintenance plan would establish consistent practices to improve the safety in all areas of the home and the equipment at the home.

There was no evidence of any environmental risk assessments of the premises which would help mitigate potential risk to people using the service.

There was a domestic bath located on the first floor of the home which we were told was not in use because

no person living at Richard House Care Home was able to step into the bath. We were also told that no-one used the second bath on the first floor and this bathroom was used by staff. On the ground floor of the home were two shower rooms. One was a walk in shower, which we were informed two days following our inspection was not routinely used because the water did not drain properly and staff would not use the plastic over shoe protectors. The other shower, which was accessed down a step, would not be suitable for some people to use. We asked if a risk assessment had been undertaken to minimise the risk for the people who used the step down shower. We were told that these had not been undertaken; however we were sent copies of completed risk assessments following the inspection. This meant there were only two showers for up to twenty nine people to access. In addition all the people living on the first floor had to come down in the lift to access the shower rooms. This was discussed with the senior carer on duty and following day three of the inspection we received email confirmation that quotes were being obtained for a new wet room.

The above examples demonstrate a breach of Regulation 15 (1) (a) (e) (f) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Situated on the ground floor of the home were two fire plans relating to the layout of the home. No Personal Emergency Evacuation Plan (PEEP's) were in place relating to people who used the service. However the week following the inspection we received confirmation from the senior carer that PEEP's had been completed and were to be printed off and put in care files. These plans should detail the level of support the person would require in an emergency situation. While these were not it place in meant that in the event of an emergency people could have been at risk of not being evacuated effectively.

During this inspection we saw that not all appropriate safety checks had been carried out to ensure people were cared for in a safe environment. We saw evidence that the fire extinguishers had been checked in January 2016, there was a current gas safety certificate, the hoist had been serviced in September 2016 and that the passenger lift had been serviced. However there was no evidence of an electrical safety certificate and some electrical appliances had not had a portable appliance test (PAT) to ensure they were safe to be used. Following the inspection we received email confirmation that the PAT testing had been undertaken.

There was no evidence of water temperature testing, nurse call bell testing, or checks that window restrictors in place were in good working order. We saw that the means of escape from the building was checked; however we were told there were eight means of exiting the building in an emergency but the record did not evidence which exit areas had been checked. This meant the registered provider could not be sure that people were cared for in a safe environment.

We saw that an emergency fire exit door was in one of the bedrooms located on the first floor of the building. A risk assessment had not been undertaken to ensure the safety of the person living in that room although we were sent a completed risk assessment following the inspection.

In May 2016 a person living at Richard House Care Home left the building without staff knowledge which put that person at significant risk, although they were found and brought back safely to the home. During this inspection we saw that the key to the front door of the building was left in the door lock and the senior carer confirmed that was normal practice, this meant that anybody living at Richard House was able to leave the building potentially without staff knowledge. We asked following the above incident if any risk assessments or safety checks had been undertaken to satisfy the registered person that nobody else would be at risk of harm if they left the building without staff knowledge. We were told that no safety checks or risk assessments had been undertaken. However following the inspection we received confirmation that a risk assessment had been undertaken for each person living at the home.

We looked at the care files for four people living at Richard House Care Home. We saw that some identified care needs did not have a corresponding plan of care to direct care staff how to meet these needs. For example in one file we saw that the monthly review had identified that antibiotic cream had been prescribed for a sore, antibiotics had been prescribed for a urine infection and following a fall resulting in a fracture to the persons finger, a splint and sling had been applied. There were no plans of care in place to meet these identified care needs. We saw the monthly review identified that the person was 'not walking' but the 'care plan and preferences and instruction' sheet had not been updated to reflect this change of care need because it stated 'all staff to encourage [the service user] to walk in and out of the dining room'. This meant there was a risk that these individual, identified care needs may not have been met.

The above examples demonstrate a breach of Regulation 12 (1) and (2) (a) (b) (d) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

We saw a staff recruitment and selection policy, dated February 2015 and an equality and diversity policy, although this was not dated. The aim of such policies is to ensure that a transparent and unbiased recruitment and selection process is followed; one that results in the appointment of the best candidate, based solely on merit and best-fit with the service's values, philosophy, and goals.

During the inspection we reviewed four staff personnel files. In all of the four files we looked at we saw evidence that a Criminal Records Bureau (CRB) checks which are now called Disclosure and Barring Service (DBS) checks or a DBS check had been carried out. The DBS is a national agency that holds information about criminal records. DBS checks aim to help employers make safer recruitment decisions and minimise the risk of unsuitable people being employed to work with vulnerable groups of people.

In all four files we saw completed application forms, two references and a job description. In three files we saw proof of address and proof of identification. However in one file we saw two copies of a passport with different passport numbers with no explanation and there was no proof of address. This meant that appropriate safety checks had not been undertaken prior to the staff member taking up post.

Two days following the inspection we received some information informing us that two people employed by Richard House Care Home had not had a DBS check. We contacted the service and it was confirmed by the registered manager that one person had been employed by the home since 2009 and the other person since 2015 and no DBS checks had been undertaken. There was no evidence provided that either person had been through a recruitment process as set out under
Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This meant the above examples demonstrate that not all appropriate checks had been undertaken to ensure only suitable staff were employed.

The above example demonstrate a breach of regulation 19 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

An established staff team supported people who lived at Richard House Care Home which meant that people were cared for by staff who knew them well.

Care staffing levels in the home consisted of one senior carer and four care staff from 08.00 to 17.00, one senior carer and two care staff from 17.00 to 22.00 two care staff from 22.00 to 08.00. The registered manager worked on a supernumerary basis.

We looked at the staffing rotas for a four week period which confirmed that levels of staffing were consistent on a day to day basis and staff we spoke with felt there were enough staff to meet people's needs. People living at the home and visiting relatives told us they thought there were enough staff on duty and call bells were answered promptly.

We were told there was no formal tool used to determine the number of staff and range of skills required in order to meet the needs of people using the service and keep them safe at all times. Staffing levels and skill mix must be continuously adapted to respond to the changing needs and circumstances of the people using the service.

We recommended that the provider implements the use of a staffing tool so that the registered provider could be assured that the number of staff and skill mix could safely meet all the needs of the people living at Richard House Care Home.

Although seven staff had undertaken first aid training we saw that there was not an identified first aider working on each shift. It was discussed with the senior carer that to help reduce the risk to people there should be an identified first aider on duty each shift in case of an emergency.

All of the visiting relatives spoken with told us they felt confident that their relative was safe and well cared for. One person said, "I have never seen anything that has worried me and I have no concerns what so ever." They said "I feel 100% better now [their relative] lives here I feel he is safe and well looked after." Another person said "yes I think [their relative] is safe here."

People we spoke with told us they were happy living at Richard House Care Home and the staff were nice and kind. One person said "I do feel safe". Another person said "I feel very well and I am well looked after."

Staff we spoke with had an understanding of their role in protecting people and making sure people remained as safe as possible. We saw from looking at the training matrix that all staff had undertaken safeguarding adults training during 2015/2016. Staff had access to a safeguarding adults policy, a 'procedure flowchart' for staff to follow and they had a copy of the local authority's multi-agency safeguarding adult's policy.

We saw staff had an understanding and had access to a Whistle Blowing policy although it was noted the policy was dated December 2007 and made reference to the outdated National Minimum Standards for Care Homes for Older People. The Whistle Blowing policy is a policy to protect an employee who wants to report unsafe or poor practice.

Requires Improvement

Is the service effective?

Our findings

We asked to looked at the records that could demonstrate how often staff received supervision and appraisals. There was no evidence of any policies or procedures relating to staff supervision or appraisal.

We looked at the records for four members of staff and saw that two members of staff had received an annual appraisal in April 2016. There was no evidence of an appraisal being undertaken for the other two members of staff.

The senior carer we spoke with told us that supervision was provided either every six weeks or six times a year but they we not sure which. However we did not see evidence of this in the staff files we looked at. In two of the files there were no records of any supervision taking place and in the other two files we saw one supervision session had taken place on the same day as their annual appraisal. One member of care staff spoken with told us that they had a formal supervision every six months and more frequent informal supervision. Another member of care staff told us they had recently had an annual appraisal but had only had two or three supervision sessions over the past two years.

During this inspection we asked how may staff were employed at Richard House Care Home and were told by the senior carer that twenty five staff were employed. We asked to look at the overall training record for all staff employed. The first training record we saw indicated large gaps in staff training. Following the inspection we were sent a further training record however that only had the names of twenty three staff and not the twenty five we were told were employed. This second training record demonstrated there were gaps in training for example there was no record that staff had undertaken Mental Capacity Act 2005 (MCA) or Deprivation of Liberty Safeguards (DoLS) training. No staff had completed End of Life training although we were told that the service provided end of life care and only seven staff had undertaken first aid training.

There was no evidence to demonstrate that any audits or reviews had been undertaken to assess the individual training needs of staff and to identify areas of development to ensure staff had access to the necessary support and training to carry out their job roles safely and effectively. This meant that the registered provider and registered manager had not ensured staff had the qualifications, competence, skills and experience to meet the needs of people receiving a service and that practices at the home reflected appropriate, up to date best practice guidelines.

The above examples demonstrate a breach of regulation 18 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw that the home had a basic induction process that was completed over the course of two days.

From April 2015, staff new to health and social care should be inducted according to the Care Certificate framework. This replaces the Common Induction Standards and National Minimum Training standards. From looking at the training record we saw that three staff were currently undertaking unit 1 of the care certificate.

Staff told us they communicated well with each other and staff handover meetings were held at the start and finish of each shift, this helped to ensure that staff are given an update on a person's condition and behaviour and ensured that any change in their condition had been properly communicated and understood. Information was also recorded in a diary which staff accessed to help ensure all information was being passed over to the oncoming shift.

During the inspection we looked around the kitchen and the food storage area. We saw that the kitchen was clean, well-organised and there were good supplies of food including fresh fruit and vegetables. We saw in August 2016 the service achieved a score of 5 following a food hygiene inspection which is the highest score you can achieve.

From the care files we looked at we saw attention was paid to people's food and drink and people received a nutritionally a balanced diet. The kitchen displayed information about specific dietary needs and the cook understood the specific dietary requirements of people living at Richard House Care Home. All of the people we spoke with were very complimentary about the cook and the food provided at the home. One person who used the service said, "The food is excellent, everything is home cooked and there is more than enough to eat and drink." Another person said "The food is very nice and there is always a choice especially at tea time."

As part of our inspection, we carried out an observation over the lunch time period. Lunch looked appetising and was well presented, with good portions and people were seen to be enjoying the meal. The meal served was homemade meat and potato pie with cabbage and we observed staff offering beetroot to people. Pudding was homemade sponge topped with lemon and coconut with custard. We saw that some people preferred to eat their lunch in their room so the plated meal was served on a tray with a lid on to help keep the meal warm while it was being transported to the person.

The Care Quality Commission (CQC) is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS) and to report on what we find. The Mental Capacity Act 2005 (MCA) provides a legal framework for making decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in there best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

From looking at the training record there was no evidence that care staff had undertaken MCA and DoLS training. This meant there was a risk that people may not be empowered to make decisions for themselves and that people who lack capacity may not be protected by a flexible framework that places people at the heart of the decision making process.

We were told that no person living at Richard House Care Home lacked capacity and no-one was subject to a DoLS. We saw evidence that one DoLS application had been submitted but that person no longer lived at the home.

Staff we spoke with demonstrated an understanding of the need to obtain consent prior to care being delivered or a task undertaken. We did observe staff obtaining verbal constant from people during our inspection.

Care records we looked at showed that the service involved other professionals to meet the healthcare needs of people who used the service such as, attending hospital and doctor appointments, visiting speech and language therapists, chiropodists, opticians and district nurses.
We spoke with a doctor who was visiting the home and they told us that they visited the home on a weekly basis and everybody had a review at least every three months. They told us that "Staff were extremely knowledgeable and helpful." They said appropriate referrals were received in a timely manner and the staff were very receptive to the changing needs of people and any specific care instructions or recommendations they made about a person were followed by the care staff.

Good

Is the service caring?

Our findings

The home had an equality and diversity policy and a privacy and dignity policy. However we saw the review date for the equality and diversity policy was dated 29 October 2008 and the privacy and dignity policy was dated July 2014. Both policies made reference to the outdated National Minimum Standards for Care Homes for Older People.

People living at Richard House Care Home told us they were happy and the staff were nice. One person said "I couldn't be looked after any better, I couldn't have chosen a better place to live." Another person said "The staff couldn't be more helpful they help me a lot and the atmosphere here is very nice."

A visiting relative told us they were very happy with they care their relative received. They told us the staff were good at respecting people's privacy and dignity and they encourage people to have choice and promote independence. We were told that since moving into the home their relative looked settled and was happy.

A visiting doctor said "The staff here are fantastic, they are so caring they are exceptional." They told us the staff know the people living at Richard House Care Home very well and there was a high level of trust within the home.

The senior carer told us that people were free to visit the home at any time although they were asked if possible not to visit during meal times and the visitors we spoke with confirmed this. We observed that visitors were made to feel welcome and we saw visitors come and go freely during the course of our inspection.

The care workers we spoke with demonstrated a good knowledge of the people who used the service and their individual personal preferences. We saw that people were addressed by their preferred names and spoken to in a friendly, respectful and kind manner. One member of staff said "I love working here we are all friendly and we have a lovely homely atmosphere." Another member of care staff said "I think this is a marvellous home, the personal care here is fantastic, this is a lovely friendly home."

We observed that people were all well-groomed and appropriately dressed. The atmosphere felt calm and relaxed and people were seen to be freely moving around the home between the different communal areas or staying in their room if that was their preference. People looked comfortable and relaxed in their surroundings and in the company of staff.

We saw that staff were kind, patient and respectful in their interactions with people.

The senior carer told us that at the time of this inspection no person using the service was receiving End of Life care but it was a service they did provide. We were told that three staff members had undertaken end of life training although the training record sent to us following the inspection did not evidence this. This meant without the specific training there was a risk that people could potentially receive inappropriate End

of Life care. However the doctor we spoke with during the inspection said "They are amazing with palliative care and are very knowledgeable."

We asked the senior carer if there were any details of local advocacy services and were told no. However we did see a contact number included in the combined statement of purpose and service user guide that people were given on admission to the home. An advocacy service provides an independent advocate who is a person who can help access information on a person's behalf and / or represent a person's wishes without judging or giving their personal opinion.

Requires Improvement

Is the service responsive?

Our findings

During our inspection we reviewed the policy in relation to complaints. We found a complaint notice on display in the main entrance hall of the home. However we also saw two other complaint policies that were out of date. In the combined statement of purpose and service user guide we saw an out to of date complaint policy dated 2008, and it made reference to the previous regulating authority, CSCI (Commission for Social Care Inspection) and their contact details that were no longer relevant.

We looked at the 'compliant file' and saw a further complaint policy referring to NCSC (National Care Standards Commission) who were the regulating body that ceased to exist in 2003. We saw that the file had a complaints dating back to 2004, 2007 and 2009 and the file contained inappropriate information. For example we saw copes of staff rotas and blank registered person/external line manager visits forms. We saw a complaint that had been analysed by Stockport quality team in March 2015 and had sent a list of the concerns raised by the complainant to the registered manager to respond to. We saw the registered manager had handwritten a response but there was no evidence that a response had been sent to the quality team or an outcome to the complaint that was raised. This meant there was a risk that appropriate action had not been taken in response to any failures identified. We received email confirmation post inspection that the complaint file had been reorganised.

We did not see any evidence that complaints were audited or analysed and there was no evidence of lessons learnt. This meant that there was not an effective system for identifying, receiving, recording, handling and responding to complaints.

The above examples demonstrate a breach of regulation 16 (1) (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

All the visiting relatives we spoke with told us they had no complaints. One person said "I have never made a complaint but you can talk to them [the staff] about anything because they are very approachable". Another comment was "No I haven't needed to make a complaint."

The senior carer on duty told us that people had their needs assessed before they moved into the home and people were encouraged to visit the home and meet the staff and other people living at the home before they made a decision about moving in. In three of the four care files we looked at there was no evidence that a pre admission assessment had been undertaken and in the fourth file we saw a very basic form titled 'Richard House admission information' that did not constitute a detailed assessment of needs. This meant the provider could not be sure that the service could meet all of the individual needs of the person.

We recommended that the service further develops the pre admission assessment form to ensure they can fully meet all of the person's individual care needs.

We looked at the care files for four people who used the service. We saw they did not have individual plans of care for each identified care need. Instead there was a document titled 'overview of clients care and

preference.' We saw that this document included some person centred information of how that person would like some of their care delivered. For example, the person's preferences around night time checks, which communal room their like to sit in and how often they would like their hair set. However the files did not contain detailed instructions of how care staff should meet all of their known assessed needs. For example one care file stated the person required assistance to change their colostomy bag but there were no details of exactly what assistance was required. In another care file we saw that the person required 'all staff to encourage [the person] to walk in and out of the dining room 'but there were no specific instructions as to what that meant. The overview documents identified that people required assistance with personal care but did give specific instructions as to exactly what assistance was required and did not include instructions how to meet people's oral health care. This meant there was a risk that some people's care needs may not be met in line with their individual assessed needs and personal preferences.

We recommended that the service considers reviewing people's plans of care to ensure where possible they are developed in partnership with the service user and are designed to meet the specific individual needs and personal preferences of the person living at Richard House Care Home.

Relatives of people using the service told us that they felt their relative's needs were being met. One person told us, their relative looked well cared for and they were walking much better since moving into the home

We heard people living in the home communicating well with staff and each other and we saw people freely expressing their needs. We saw that staff responded appropriately in supporting people.

We asked staff and people living at Richard House Care Home what activities were available. The people and the staff we spoke with told us that an entertainer came into the home in July of this year and everybody enjoyed that. They also told us that activities were limited. One person living at the home said "There are no activities." Another person when asked about activities said "There is no stimulation."

One member of staff we spoke with said "There is not a lot going on but we do have an outside entertainer twice a year." Another staff member told us there were not a lot of activities but staff do take people to the local park, shops and a local café when they are able to. The senior carer on duty told us that a local pottery shop comes into the home about twice a year to help people make pots and paint them after they have been in the kiln. We were told staff did nail painting, held DVD afternoons and a mobile library and a book club come into the home on a monthly basis. We were also told that the home received visits from members of local churches and recently some people did knitting squares for a Noah festive at one of the local churches.

Due to the lack of regular, personal, meaningful activities there was a risk people were not individually encouraged or stimulated to help maintain and improve their wellbeing.

We recommended that individual assessments of people's hobbies and interests were undertaken and recorded to ensure that the activities provided were in accordance with people's personal preferences.

One relative we spoke with told us they took their relative out every week and the staff were good at facilitating this weekly event.

Inadequate

Is the service well-led?

Our findings

At the time of this inspection a Registered Manager was in post although they were not available due to being on annual leave. The registered manager had been in post since January 2010.

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

We saw that policies and procedures were available and accessible to staff. However some of the polices for example complaints, whistleblowing , equal opportunity's , manual handling, lavatory and washing policy made reference to the outdated National Minimum Standards for Care Homes for Older People. This meant staff were not provided with access to up to date information that reflected current legislation and best practice guidance to support them in their roles and people using the service could be at risk of receiving unsafe and inappropriate care.

We found the registered manager had failed to establish and operate effective systems to assess, monitor and improve the quality of service; had not mitigated the risks relating to the health, safety and welfare of people who used the service and did not effectively asses and monitor all aspects of the quality of the service.

There were no structured processes in place for regularly auditing care plans, staff training, complaints, safeguarding, infection control and general cleanliness of the home and all aspects of the medication administration records. This had resulted in many of the shortfalls and breaches of regulations we had found during the inspection process.

The Health and Social Care Act (2008) Regulated Activities Regulations (2014) Schedule 3 sets out the information required when employing people. As there was no audit process in place for staff files the provider could not be sure that the appropriate information had been received for each member of staff to ensure as far as possible there were of good character.

We looked at the record of accidents/incidents within the service. We saw although there was a record of accidents and incidents the last analysis was dated July 2014 to December 2015. A regular review would have provided the registered manager with an overview of the types of accidents and incidents that had occurred, if there were any reoccurring patterns and what action, if any, was needed to mitigate risk.

We asked if there was an information booklet, a statement of purpose or a service user guide that was available for people. We were given combined statement of purpose and service user guide. We saw that this booklet was out of date. For example the comment, complaints and suggesting policy date 2008 had details of the previous regulating body, the Commission for Social Care Inspection (CSCI) and their contact details that are not obsolete and the accident report policy also made reference to CSCI. The

accommodation and admission section made reference to the home having a stair lift as well as a passenger lift. We saw a passenger lift but there was no stair lift. This meant that up to date information about the service was not available to people to help them make an informed decision about whether or not to live at Richard House care Home.

The above examples demonstrate a continued breach of regulation 17 (1) (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We were told that service operated an open door policy for people living at the service. Visitors to the service or staff could speak with the registered manager or a senior member of staff at any time. People spoken with confirmed this. The senior carer told us that formal staff meetings were not held. However we were told that twice a day at approximately 10.30 and 13.30 an informal 15 minute meeting was held with the staff on duty to discuss any issue that might have arisen during the shift.

We saw that feedback questionnaires had been sent out to people living at Richard House Care Home and their relatives in May 2016. We saw some of the completed questionnaires and with the exception of one which stated they were not very satisfied with activities they were very or quite satisfied with the service delivery. The senior carer told us they were in the process of collating the information with a view to producing a short report based on the results. In addition we saw that a staff survey had also been sent out in May 2016 but the results had not yet been collated. We saw feedback was positive for example: the staff genuinely care, we work as a team, we get job satisfaction, feels like home from home and good teamwork. Some other comments included: would like more time to chat with residents and would like more training.

We saw that in 2015 a food survey had been undertaken with the people living t the home and a report was produced on the results. The report identified that 90% of people liked to sit at the dining room tables, 80% of people described the food as being good and 20% described the food as being excellent. No negative comments had been received about the food provided.

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 We found that the provider had not protected people against the risks associated with the safe administration and management of medicines. Regulation 12 (1) (2) (g) We found that the registered manager had not taken all reasonable steps to help manage and reduce the risks ensuring the health, safety and welfare of people. Regulation 12 (1) (2) (a) (b) (d)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment We found that the provider was not monitoring the levels of cleanliness and not all environmental risk assessments were in place. Regulation 15 (1) (a) (e) (f)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints There was not an effective system for identifying, receiving, recording, handling and responding to complaints. Regulation 16 (1) (2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed

We found that the provider did not have robust recruitment process in place to ensure people using the service were kept safe. Regulation 19 (2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing People were not protected against the risks of unsafe or inappropriate care as staff had not received all necessary direction and support to carry out their role. Regulation 18 (2) (a)