Denmax Limited

Richard House Care Home

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection was carried out over three days on the 22, 23 and 24 May 2017. Our visit on 22 May 2017 was unannounced.

At the last inspection on 19, 20 and 21 September 2016 the overall rating for the service was requires improvement, with the well led section found to be inadequate. At that inspection we identified multiple regulatory breaches of the Health and Social Care Act 2008 (Regulated Activities) 2014, which related to medication administration, premises and equipment, receiving and acting on complaints, fit and proper person's employed, safe care, staffing and good governance.

Following the inspection the provider sent us an action plan detailing how the identified breaches would be addressed. This inspection was to check improvements had been made and to review the ratings.

Richard House Care Home is located in the Cale Green area of Stockport and is registered to provide accommodation for up 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 facilities.

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

At the time of our inspection there were 22 people living at Richard house Care Home.

The home had a manager registered with the Care Quality Commission (CQC), who was currently on sick leave and not present throughout the three days of inspection. CQC had been appropriately notified of this sick leave. The acting manager was present for the first two days of the inspection and a senior carer was present for the third day of the inspection. A registered manager is a person who has registered with CQC 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.

During this inspection, we found significant improvements had been made; the acting manager and senior care staff we spoke with were responsive to our feedback and were committed to further improving the service delivered to people living at Richard House Care Home. At this inspection we identified a breach of one regulation of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was in relation to good governance.

We observed people receiving person-centred care and staff were able to describe the individual care needs

of people, but we found some shortfalls in the written plans of care. This was because some parts of the plans of care were pre-printed and staff used a tick box approach to identify if the care need related to the person. This meant that some parts of the plans of care were vague and did not include details of exactly what assistance the person required to meet their assessed care needs.

As stated above during the inspection we found significant improvements had been made since the last inspection. However we found that robust systems had not yet been implemented to monitor all aspects of the quality and safety of the service being provided.

We observed staff giving kind and caring support to people. We saw that people's privacy and dignity was respected and people were relaxed in the company of staff.

Improvements had been made to medication administration and we saw medicines were managed safely and people were receiving their medicines in line with the prescriber's instructions.

Since the last inspection the recruitment processes had been improved to ensure only suitable staff were employed to work in the service.

From looking at the training record and speaking with staff, we found improvements had been made to ensure staff were properly trained and future training had been planned.

Since the last inspection staff had received on-going supervision and an annual appraisal. This meant that staff were being appropriately guided and supported to fulfil their job role effectively.

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.

The home was clean and we saw staff had access to personal protective equipment (PPE) to help reduce the risk of cross infection.

Staff understood how to recognise and report abuse which helped make sure people were protected. People living at Richard House Care Home, the staff, the visiting relatives and the healthcare professional spoken with all said they thought safe care and treatment was provided.

People had access to healthcare services and we saw specialist advice was sought in a timely manner, for example from the district nurse, dentist, optician and chiropodist. People were supported to attend hospital appointments as required.

Attention was paid to people's diet and people were supported to eat and drink in a way that met their needs. People living at Richard House Care Home were complimentary about the food provided and said there was plenty of it.

A notice informing people how to make a complaint was displayed in the main entrance of the home and in the dining room. Details of how to make a complaint were also detailed in the home's statement of purpose and service user guide. There was a system in place for receiving, handling and responding to concerns and complaints. The people living at Richard House Care Home who we asked and all of the visiting relatives we spoke with told us they had never raised a complaint but thought the manager would be responsive if they did.

The visiting healthcare professional we spoke with told us they had no concerns for the people living at Richard House Care Home and told us staff were knowledgeable and proactive in their care delivery.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

There were appropriate systems in place for the effective ordering, control, management and administration of medicines.

Employee recruitment processes in place helped to make sure new care workers were suitable to work with vulnerable adults.

The home was clean and personal protective equipment was available to staff to help reduce the risk of cross infection.

People told us they felt safe and there were appropriate procedures in place to protect people from abuse and maintain their safety.

Is the service effective?

Good

The service was effective.

Staff members had received an annual appraisal, supervision and training to help make sure people were provided with care and support that met their needs.

Staff understood the need for and sought consent from people before providing care or support.

Other health and social care professionals were appropriately accessed for advice when needed.

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.

People's care records were stored securely to maintain confidentiality.

Is the service responsive?

Good

The service was responsive

We saw that people's needs were assessed prior to admission to the home.

Staff were knowledgeable about people's individual care needs and their personal preferences.

There was a system in place for receiving, handling and responding to concerns and complaints.

Is the service well-led?

Requires Improvement

The service was not always well led.

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

Robust systems had not been fully implemented in order to monitor the quality of the service.

The acting manager understood the legal obligation to inform the Care Quality Commission of any reportable incidents that had occurred at the service.

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 22, 23 and 24 May 2017. Our visit on the 22 May 2017 was unannounced. The inspection team consisted of one adult social care inspector.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed all the information we held about the service. This included previous inspection reports, the provider's' action plan following the last inspection in September 2016. We also reviewed notifications that the provider is required to send to us of certain incidents for example the death of a service user, a safeguarding matter or serious injury, so that the Care Quality Commission (CQC) can assess if appropriate action had been taken and the relevant people had been alerted.

We sought feedback from Stockport Healthwatch, Stockport's Local Authority Quality Assurance team, the Pharmacist from Stockport's Clinical Commissioning Group (CCG) and the Control of Infection Unit and they shared reports of their most recent monitoring visits to the service. No issues of concern were received. However the Local Authority Quality Assurance team told us suggestions had been given to support person centred care plans. We considered this information as part of the planning process for this inspection.

During our inspection, we spoke with the acting manager, three senior carers, two care staff, one cook, one domestic, three visitors, one visiting healthcare professionals and nine people living at Richard House Care Home.

We looked around the building including some bedrooms, all of the communal areas, toilets, bathrooms, the kitchen and the garden area.

We examined the care records of four people living at Richard House Care Home. We reviewed a sample of

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 assurance systems.

Good

Is the service safe?

Our findings

At our last inspection in September 2016, we found that the registered provider had not protected people against the risks associated with the safe administration and management of medicines. At this inspection we found that improvements had been made in this area and the registered provider was meeting the requirements of this regulation.

During the inspection we looked at the systems in place for the management of medicines. We checked the systems for the receipt, storage, administration and disposal of medicines in the home.

At the last inspection during a tablet count of individually boxed medication we found discrepancies with the number of tablets being signed as given and the actual number of tablets in the box. This meant there was a risk that people may not have received their medication as prescribed by their General Practitioner (GP), which could put them at risk of harm. During this inspection we found significant improvements had been made. We saw a system had been implemented where on a monthly basis a tablet count was undertaken for boxed medication and no discrepancies had been identified.

We saw that eye drops with a limited life span had a recorded date of opening which reduced the risk of people being given out of d date medication.

We saw that creams and ointments were prescribed and dispensed on an individual basis. Since the last inspection we saw the implementation of topical cream charts and a relating plan of care, which included the name of the cream or gel, what it was being used for and where and how often it was to be applied.

At the time of our visit although we were initially told that nobody was self-administering their own medication, we were later told that one person was administering their own insulin. We saw that a risk assessment had been undertaken to ensure the person was able to safely administer their own medication.

We saw there were appropriate policies and procedures in relation to medication administration, which staff had access to and these provided staff with guidance on how to maintain the safe storage and administration of medicines. Medicines were administered by care staff who had received appropriate training in storing, checking, administering medicines and disposal of medication.

We saw a list of staff signatures to show the signature of those staff with the responsibility for administering medication. Such a list would enable the registered manager to identify staff that had administered medicines or made an error.

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. A visual check of the cassettes demonstrated that medication had been given to people as prescribed by their General Practitioner (GP).

We found no excessive stocks of medication being stored.

We found that appropriate arrangements were in place for the storage of controlled drugs which included the use of a controlled drugs register. However we told that no person was currently prescribed any controlled drugs. Controlled drugs are prescribed medicines frequently used to treat conditions such as severe pain. These medicines are liable to abuse and for these reasons there are legislative controls for some drugs and these are set out in the Misuse of Drugs Act 1971 and related regulations. Part of the control requires services to make entries of any controlled drugs stored and administered in a separate register as well as on the Medication Administration Records.

There was a system in place for recording the daily temperature of the medication fridges to monitor that medication was stored at the correct temperature.

We asked how the home stored and recorded any medication that was to be disposed of. We saw that arrangements were in place and a record kept of medication that was waiting to be picked up by the dispensing pharmacy which the pharmacy signed for when they picked them up. This is in line with the current National Institute for Health and Care Excellence (NICE) guidance which provides national guidance and advice to improve health and social care. It develops guidance, standards and information on high quality health and social care.

At the last inspection we found that the registered provider had not undertaken all the necessary safety checks to help manage and reduce risk ensuring the health, safety and welfare of people. At this inspection we found that improvements had been made in this area and the registered provider was now meeting the requirements of this regulation.

We reviewed the safety certificates for the building and found all relevant safety and maintenance checks had been carried out, and safety certificates seen were in order. This meant that the building was well maintained and safe to use. For example we saw evidence of gas and electric safety certificates, lift and hoist servicing, Legionella testing and portable appliance testing (PAT).

We saw that appropriate safety checks were carried out to ensure people were cared for in a safe environment. For example we saw weekly checks of the nurse call bells, fire alarm testing, emergency lighting, water temperature delivery testing, window and ventilation checks which included checks of window restrictors. In addition we saw that since the last inspection alarms had been fitted to all external doors and fire exit doors which would alert staff if anybody opened any of the doors.

During the course of the inspection we saw a new call bell system was installed. The new system recorded how often a person's call bell was rung, the length of time it took for staff to answer the call bell and how long the care staff was with the person attending to their needs. The new call bells were wall mounted but were also detachable so could be used from wherever the person was sat. They had been installed in all bedrooms and all of the communal areas of the home including bathrooms and toilets. In addition individual pendant alarms were available for people so they were able to immediately summon help if needed.

We saw that people living in the home had a Personal Emergency Evacuation Plan (PEEP). These plans detailed the level of support the person would require in an emergency situation. This meant in the event of an emergency evacuation the risk to people being evacuated effectively would be reduced. There was a floor plan and a roll call list at each fire alarm point which had the room numbers for that area and the nearest fire exit. We saw that all staff had undertaken fire safety training and two staff members were the

nominated fire marshals.

Risk assessments were in place for people which covered areas such as, nutrition, moving and handling and the risk of falls. These provided information to staff on how to manage identified risks. We saw the acting manager was in the process of implementing environment risk assessments to help reduce the risk to people living, working and visiting Richard house Care Home.

We saw there was a clearly identified first aider working on each shift in case of a first aid emergency. This meant the first aider on shift would lead any emergency situation should one arise.

At the last inspection we found that the registered provider did not have robust recruitment process in place to ensure suitable staff were employed. At this inspection we found that improvements had been made in this area and the registered provider was now meeting the requirements of this regulation.

During this inspection we looked at the recruitment files of four members of staff. The files were organised and contained a completed application form, two references, interview notes, and proof of identity, proof of address, a job description and a medical questionnaire. Pre-employment checks had been carried out with the Disclosure and Barring Service (DBS).The DBS identifies people who are barred from working with children and vulnerable adults and informs the service provider of any criminal convictions noted against the applicant.

The acting manager told us that since the last inspection, the service had updated the recruitment process and had introduced the involvement of people living at Richard House Care Home in the interviewing of candidates and the overall decision process. We spoke with person who confirmed this. The acting manager said this was to give the people living at the home a greater voice in who was employed to help care for them.

People who lived at the home told us they felt safe. One person said "I have no worries at all and yes I do feel safe." Other comments included "I am quite happy and I feel safe, the staff are fantastic." "They look after you very well here" and "I feel very safe here, we are very fortunate it is a good place to be."

All of the visitors and the visiting healthcare professional we spoke with told us they were confident that people were kept safe from harm. One relative said "I have no worries about abuse, [their relative] is very happy here." Another visitor when asked about safety said "I have no concerns about safety; I have never seen or heard anything that has worried me."

Staff we spoke with had an understanding of their role in protecting people and making sure people remained as safe as possible. Staff had access to the local authority's multi-agency safeguarding adult's policy. In addition we saw a procedure flow chart on display in the office which included relevant contact telephone numbers should staff need to report any issues of concern.

There had not been any allegations of abuse since the last inspection and the acting manager was aware of the need to notify the Care Quality Commission (CQC) should any allegation be made.

We saw staff had access to a Whistle Blowing policy and understood the policy. The Whistle Blowing policy is a policy to protect an employee who wants to report unsafe or poor practice. All staff spoken with said they would feel confident to report poor practice.

We looked around the home, at all the communal areas, toilets, bathrooms, the kitchen, and some of

bedrooms on both floors of the home. We saw that the kitchen was clean and there were adequate supplies of food, which was all appropriately stored. We saw that appropriate safety checks had been undertaken. For example fridge and freezer temperatures were recorded and there was a cleaning schedule in place for the kitchen. We saw that cooked food temperatures were taken prior to food being served to people to ensure food was served at the correct temperature. Although we did not see any opened food in the fridge the cook told us that any opened food would be covered and would have a recorded date of opening to ensure that people were not put at risk of eating out of date food.

The Food Standards Agency had conducted an inspection in August 2016 of the kitchen and the home was awarded the rating of a Level 5 (Excellent) which is the highest rating that can be achieved. We saw that an independent company was employed by the registered provider to undertake three monthly audits of the kitchen to ensure the high standards of cleanliness were maintained.

During our last inspection we found that there was no recorded evidence of maintenance work that had been undertaken. During this inspection we saw a record of required maintenance work and evidence that the work had been undertaken. We saw a programme of planned refurbishment and an anticipated completion date. Since the last inspection we saw that CCTV had been installed to the outside of the building and in the corridors. This was done in consultation with the people living at Richard House Care Home and their relatives in response to a break in where a person was able to gain entry into the home. We saw that bath aids had been fitted to the two baths on the first floor of the home, which meant people were now able to have a choice between a bath or shower. We saw that new flooring had been laid in both dining rooms and part of the ground floor corridor. The acting manager told us it was their intention to replace the flooring in the first lounge and the whole of the ground floor corridor. We also saw that the acting manager was in the process of creating a small quiet reading area for people to enjoy.

We saw that the home employed the services of four domestic staff and a person who worked in the laundry. People living at Richard House Care Home and visiting relatives told us they found the environment was kept clean and tidy. One visiting relative said "[their relatives] room is always immaculate." Some comments from people living at the home said "I have a very nice room and it is kept scrupulously clean" and "I have a nice room and it is nice and clean."

We were told that the acting manager was the infection control lead. This meant they were responsible for ensuring a high standard of cleanliness was maintained throughout the home and that staff were following the Department of Health prevention and control of infection in care homes guidance.

Since our last inspection of the service we found that detailed cleaning schedules had been implemented and the acting manager had implemented an annual infection control audit that had been undertaken in October 2016. In addition a twice weekly audit had been implemented of the whole building to ensure standards of cleanliness were being maintained. This was last undertaken on 19 May 2017. No areas of concern were identified.

During the inspection we saw all areas of the home including the hoist and wheelchairs were found to be clean.

We saw that Stockport Metropolitan Borough Council Health Protection and Control of Infection Unit had undertaken an audit in April 2017. No major issues had been identified.

We saw that the home had infection control policies and procedures and a waste management contract. During our inspection we saw personal, protective equipment (PPE) such as disposable aprons and gloves

were available throughout the home as was liquid soap dispensers, paper handtowels in the communal toilets and bathrooms and hand sanitiser, all of which would help reduce the risk of cross infection.

We saw the use of colour coded mops and buckets for cleaning and we saw good stocks of cleaning products which helped staff to maintain good standards of hygiene and cleanliness throughout the home.

All cleaning products were securely stored to ensure people's safety. We saw Substances Hazardous to Health (COSHH) safety data sheets had been obtained for the cleaning materials used in the home and a copy was kept in a file that was accessible to staff. COSHH is the regulation that requires employers to control substances that are hazardous to health.

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 and had worked with them for some time and had got to know them well.

We looked at the staffing rotas and how the service was being staffed. We did this to make sure there was enough staff on duty to meet people's needs. Observations of the staffing levels during the inspection confirmed the staffing numbers and skill mix were sufficient to meet people's needs.

During the inspection we did not see that any person had to wait an excessive length of time before staff responded and provided assistance.

Good

Is the service effective?

Our findings

At our last inspection in September 2016, we found people were not protected against the risks of unsafe or inappropriate care because care staff had not received all necessary direction and support to carry out their role. At this inspection we found that improvements had been made in this area and the registered provider was now meeting the requirements of this regulation.

Since the last inspection we saw from looking at the supervision and appraisal tracker document that staff had received an annual appraisal and were receiving on-going supervision sessions. Staff spoken with confirmed this to be the case. Formal supervision was used at regular intervals to observe, discuss and evaluate the quality of the care worker's individual performance and where best practice was in place. Appraisals and supervision are important as they ensure staff are supported and are able to discuss in private their personal development and further training needs as well as being able to discuss any issues in relation to their work. Staff we spoke with told us they found supervisions and appraisal useful and said they felt they received good support from the acting manager.

We saw there was a basic induction training checklist which staff new to the service undertook over a two day period and a staff handbook was in the process of being developed. A staff handbook is a good way to inform newly employed staff about the values of the service and providing them with a clear understanding of their role and responsibilities. The acting manager told us that newly employed care staff worked on a supernumerary basis for their first two shifts or until they felt confident to deliver care unsupervised. Working supernumerary involved the carer working alongside an experienced care worker who could teach, or help the new carer learn aspects related to the job role before they were included in the staffing rota to deliver care to people. We saw from looking at the staff files that no new members of staff had been recruited since the last inspection.

From April 2015, staff new to health and social care should be inducted using the Care Certificate. The Care Certificate is a set of standards for social care and health workers to ensure they have the same induction, learn the same skills, knowledge and behaviours to provide compassionate, safe and high quality care and support. The Care Certificate was developed jointly by Skills for Care, Health Education England and Skills for Health and whilst undertaking the care certificate is not mandatory it is considered good practice. The acting manager told us that all newly employed care staff would be enrolled on the Care Certificate training.

We saw that staff training was recorded on the skills for care website and the acting manager told us they reviewed this weekly or fortnightly to assess the ongoing training needs of staff. The system automatically alerts the acting manager to training which is due and the acting manager then contacted the individual staff members with the required training details. We saw staff had undertaken moving and handling training, food safety, fire safety training, dementia care, health and safety, prevention and infection control training, first aid training, medication administration training palliative care, which included end of life care and safeguarding adults training.

We saw that four staff were currently undertaking National Vocational Qualifications (NVQ) level two or level

three in Health and social care. The acting manager confirmed that the majority of staff training was completed on line or by completing NCFE training. NCFE is accredited distance learning courses. In addition the acting manager accessed training provided by Stockport Metropolitan Borough Council.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

The acting manager was knowledgeable about the MCA and the need to carry out mental capacity assessments for people who required them.

The acting manager told us, and we saw information to demonstrate that an application to deprive a person of their liberty had been authorised by the supervisory body (Local Authority). The Care Quality Commission (CQC) had been informed when the authorisations had been granted.

We saw staff had access to a consent to care policy and it was apparent from speaking with staff that they had a good understanding of how and why consent must be sought to make decisions about specific aspects of people's care and support. We observed staff obtaining verbal consent from people during our inspection. For example we observed people being asked what they would like to eat and where they would like to sit. Staff were able to describe the importance of getting to know people and how people they liked things to be done. One member of staff said, "This is their home and they get to choose what they want to do and how they want it done."

In the care files we looked at during the inspection we saw that people had signed their consent to receive care and treatment, consent to have their photograph taken, consent to be weighed and a signed care plan authorisation document as well as consent to admission document. This demonstrated that every attempt had been made to consult with people living at Richard House Care Home and obtain their consent.

Staff told us they communicated well with each other and staff handover meetings were held at the start of each shift. In addition we saw there was a communication book which all staff on duty had access to and there was senior staff communication diary. This helped to ensure that staff were given an update on a person's condition and behaviour and ensured that any change in their condition had been properly communicated and understood.

Care records we looked at showed that referrals to other healthcare professionals had been made in order to meet the health needs of people who used the service. For example speech and language therapists, chiropodists, opticians, district nurses and the practice nurse. The home also supported people to attend hospital and doctor appointments. The visiting health care professional we spoke with told us that appropriate referrals were made in a timely manner and staff did follow instructions or recommendation's made. We were told "Staff here are knowledge about people and are very proactive."

Visiting relatives we spoke with all confirmed that the staff were prompt in contacting them if they had a concern about their relative or informing them if their relative had been unwell. One person said "They

keep me informed about this by telephoning me."

The people living at Richard House Care Home that we asked said they had enough food and drink and choices of meals were available. People were complimentary about the meals provided. One person said "The food is very good and there is always enough food. They [the staff] know I don't like fish but I do like eggs and they do eggs especially for me." Other comments included "The food is excellent, I like most of the food and its all home cooked," "The food is nice, all home cooked and nicely presented. They [the staff] are very accommodating and there is more than enough food" and "They [the staff] give you the best food, you couldn't get any better food anywhere else."

We spoke with the cook who had a good understanding of people's personal dietary preferences, including their likes, and dislike. They were able to clearly describe which people had special dietary requirements such as diabetic diets.

Care staff told us that food was cooked to a high standard and choice was never a problem.

We saw that people were fully included in choosing the meals provided. We saw a food survey had been undertaken in November 2016 with 80% of people describing the food as good and 20% describing the food as excellent. Since the survey the cook had been trying out new meals as suggested by people. For example sweet potato mash, garlic and herb mini roast potatoes, tempura king prawn salad and chicken wrapped in Parma ham.

In the care files we looked at we saw people's weight was checked and recorded on monthly basis and if there were any concerns we saw advice had been sought from the General Practitioner (GP) and the community dietician.

People had a choice of two dining's rooms and we saw the tables were nicely laid. There was a menu board on display in one of the dining rooms clearly displaying what the meals of the day were. The atmosphere in the dining rooms was relaxed and people were seen to be enjoying their meal. Lunchtime was a sociable and relaxed occasion with staff engaging well with people and offering support if required.

Good

Is the service caring?

Our findings

We observed staff interactions with people and we saw people's privacy and dignity were respected and a visiting healthcare professional and the visitors we spoke with confirmed this. Visiting relatives who we spoke with told us they thought people's privacy and dignity was respected at all times.

The people we spoke with who were living at Richard House Care Home told us they were happy and felt well cared for. One person said, "The staff are brilliant, they have been very good to me." Other comments included "They [the staff] are very good, very nice and very helpful" and "I have everything I need, they are very nice to you here." One person said "I am a bit spoilt really, I feel like I am with my own family."

Staff told us they thought that people were well cared for. One staff member said "The care here is very good; we are all like family and friends." Another comment was "We get to know our resident's very well and over time get to know what they like." Another comment was "We are a happy team and we have a calm and nice atmosphere in the home."

We saw that staff were kind, patient and respectful in their interactions with people. For example we saw one person wanted to speak with their daughter so staff brought them the telephone so they could ring their daughter. When they were unable to contact the daughter we saw staff explain to the person what day it was and that their daughter was probably at work but they would try again later for them. Another visiting relative said "The grass roots here are very friendly; the staff sit and chat with [their relative]. We were told "The staff have got to know [their relative] very well; [their relative] is comfortable and happy with that."

We saw that people were all well-groomed and appropriately dressed. Staff were observed to demonstrate a good knowledge of the people who used the service. When we spoke with staff about people's identified needs they were able to demonstrate they knew people very well and gave examples of how people preferred their care and support to be given. People were seen to be freely moving around the home. People looked comfortable and content in their surroundings and in the company of staff.

The atmosphere was relaxed and happy. One visiting relative said "The atmosphere is relaxed and friendly."

Staff and visitors we spoke with said there were no restrictions as to when people could have visitors and we saw visitors coming and going throughout the inspection. The staff appeared to know the visitors and have good relationships with them. We saw that visitors were offered a cup of tea on arrival and the visiting relatives we spoke with confirmed that this was usual practice. .

From our observations we saw that people were encouraged to remain as independent as possible. We saw care workers support people to manage tasks such as eating/drinking and mobilising around the home within their capabilities...

The acting manager told us that at the time of this inspection no person was receiving End of Life care but it

was a service they did provide. End of Life care is centred on the individual person and is geared towards helping the person to have as much control as possible about decisions relating to future care and end of life needs. We saw that staff training in Palliative and End of Life care was ongoing.

The acting manager told us that no one using the service was currently using the support of an advocate although details of local services were available in the statement of purpose and service user guide. An advocate is a person who represents people independently. They are able to assist people in many ways; such as, writing letters for them, acting on their behalf at meetings and/or accessing information for them.

We saw that people's belongings were treated with respect. When we looked in bedrooms, we saw that a high standard of cleanliness was maintained, and clothes were hung appropriately in wardrobes.

Records and documents were kept securely and no personal information was on display. This ensured that confidentiality of information was maintained. Records showed people and their relatives were involved in decisions about their care and care plans were reviewed approximately every three months or more frequently if necessary.

Good

Is the service responsive?

Our findings

At our last inspection in September 2016, we found there was not an effective system for identifying, receiving, recording, handling and responding to complaints. At this inspection we found that improvements had been made in this area and the registered provider was now meeting the requirements of this regulation.

We saw that the complaint procedure had been updated since the last inspection; there was now a complaint notice on display in the main entrance hall and in the dining area and a copy also included in the statement of purpose and service user guide, which was available for people to access in the front porch seating area.

All of the people and visitors we spoke with told us they had never made a complaint but would do if they had any concerns. One visitor said "I have never made a complaint but feel they would listen and sort it out if I did." Throughout the inspection we saw the acting manager made them self available if anybody wanted to speak with them and they told us they encouraged people to raise any issues or concerns at an early stage so they could be swiftly dealt with.

We looked in the complaint file and saw no formal complaints had been recorded since the last inspection. We saw that two verbal issues had been raised by relatives and the appropriate action had been taken.

We saw there was also a record of compliments received. One comment from a visiting healthcare professional was 'wonderful home.' Other written comments were 'excellent care,' 'very professional' and 'Smells nice.'

Since the last inspection we saw that people's care files had been reviewed and updated. We saw the use of pre-printed care plans had been implemented. The pre-printed care plans were generic, with vague statements and staff ticked the sentence that best applied to the person. They were not person centred and did not give specific, personal details or instructions for care staff to follow in order to meet the person's need. For example a care plan for sleep and rest had a ticked pre-printed statement 'discuss normal sleep pattern and provide an environment conducive to sleep.' However there were no further details of what that specifically meant for that person and there were no directions of how staff should meet the individual care need.

We saw the care plan regarding mobility for one person had a tick against a statement 'For patients with paralysed limbs, undertake passive movement exercises to improve circulation and muscle tone' and there was a tick against a statement 'Offer bed rest breaks during the day to ease oedema.' The acting manager confirmed this person did have any paralysed limbs or oedema. This meant the care plan was confusing and contradictory.

We were told that some people required assistance with oral hygiene but there was no assessment tool in place to assess this care need and there was no care plan for staff to follow to ensure this need was met.

However the acting manager was able to describe in detail the oral hygiene needs of individual people.

This was discussed at length with the acting manager who made assurances that as a priority all care plans would be reviewed and rewritten to include specific, detailed, person centred information for care staff to follow.

During our discussions with the acting manager and staff we found they were fully aware of people's individual care needs, preferences, likes and dislikes around their daily lives and the importance of this and care staff were able to clearly describe people's individual care needs and how they met those needs. People living at Richard House Care home confirmed staff did meet their individual care needs in line with their personal preferences. However this information had not been clearly documented in people's care records which meant that accurate, complete and contemporaneous plans of care were not being kept. This has been further discussed in the well led domain of the report.

We saw that people's needs were assessed prior to admission by obtaining the 'service user assessment plan' from the relevant funding local authority. Following receipt of this information the registered manager, the acting manager or a senior carer would go and meet with the person and undertake a pre admission assessment of their needs to ensure the service were able to meet all of the person's individual needs. The acting manager told us the pre admission assessment tool was currently under review so that it included a more detailed and thorough assessment of people's needs. This was a recommendation made at the last inspection.

The acting manager said people were encouraged to come and have a look round the home and, if it was appropriate and the person was able, they would be invited to visit the home and perhaps have lunch and meet the staff and other people living at the home, before they made a decision about moving in.

The visiting relatives we spoke with said that the staff had got to know their relative very well and met their individual care needs. We saw that staff responded appropriately in supporting people according to their individual needs and personal preferences.

We saw that a combined service user guide and a statement of purpose were available for people, which included key names and contact numbers, the organisational structure of the home, the aims and objectives of the home, information regarding the facilities available including meals, the complaints procedure, plus other relevant information people who lived at the home and people who may be considering moving to the home needed to know. The acting manager told us the document were currently in the process of being reviewed and updated, once completed the Care Quality Commission (CQC) would be sent the updated Statement of Purpose as required under Regulation 12 of the Care Quality Commission (Registration) Regulations 2009.

We saw that a part time activity coordinator was in post and since the last inspection a 'Leisure and social activities' questionnaire had been undertaken with people to find out what people's individual hobbies and interests were. We saw that one person had their own tablet (IPad) and four people had their own mobile phone. One person was facilitated to have computer access so that they were able to view family photographs from abroad. This was confirmed by the person who had said they had appreciated being able to look at the photographs. We saw people had access to a mobile library and weekend newspapers were purchased for people. One person liked doing jigsaws and puzzles and we saw this person enjoying doing a jigsaw during the inspection. The acting manager told us they had developed good links with Stockport Cricket Club and were in the process of discussing people attending bowling matches during the summer.

We saw there was a weekly plan of scheduled activities displayed on the home's notice board which included cake making, arts and crafts and gentle exercises. During the inspection we saw staff sat chatting with people and playing dominos with people. A record was kept of the activities that people had attended.

Requires Improvement

Is the service well-led?

Our findings

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. A registered manager was in post at the time of our inspection although they were on sick leave. Richard House Care Home was being managed by the acting manager and the provider undertook weekly visits to support the acting manager.

At our last inspection we found the service was not well led and was rated as inadequate at that time. During this inspection we found that significant improvements had been made in this area although the registered provider was not meeting all of the requirements of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The acting manager acknowledged that at the time of the inspection they had not yet fully implemented systems to regularly assess, monitor and review all of the key functions of the home, including care practices and quality of the service being provided. For example they did not formally review or audit staff recruitment files, people's care files including the care plans or complaints. A medication administration audit had been implanted but it was not robust and lacked detail. For example one section of the audit tool asked 'have any medicines been missed, refused and have they been monitored and reported back.' The response was 'yes' yet there was no evidence of what action had been taken. Another question was 'have gaps on medication administration record (MAR) sheets been identified and staff informed.' The response was 'yes' but there was no further recorded information to confirm what action had been taken. This meant the registered provider had failed to fully establish and operate effective systems to assess, monitor and improve the quality of the service.

As discussed in the responsive domain of the report we found shortfalls that the pre-printed care plans. We found the care plans were contradictory, confusing, vague and lacked detailed instructions of how care staff should meet the individual care need of the person. This meant the registered provider had failed to ensure accurate, complete and contemporaneous records in respect to each service user.

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

Staff, visiting relatives and people living at the Richard House Care Home spoke very positively about the acting manager's leadership of the service. We were told the overall atmosphere of the home had improved and systems in the home were more organised and staff were happy in their work. Staff told us the acting manager was receptive, approachable and supportive. One staff member said "[the acting manager] is brilliant, they are very understanding, approachable with work or personal issues." Another member of staff told us they thought the acting manager "was doing a perfect job."

Visitors and people using the service expressed satisfaction with the service provided. One person we spoke

with told us the acting manager was approachable and committed.

There was a clear management structure in place and staff were aware of their roles and responsibilities. We observed throughout our inspection that the acting manager was visible within the home, interacting with people, their relatives and visiting health professionals.

On arrival we found the staff were welcoming and the atmosphere felt calm and relaxed throughout the inspection.

They acting manager and staff were receptive to our feedback during the inspection and demonstrated a commitment to further develop and improve the service delivered to people.

The acting manager was aware of the importance of seeking the feedback of people using the service and their families. We saw that service user surveys had been given out during October 2016. The results had been analysed and a short report of the results had been produced. The overall results demonstrated that people felt safe, were comfortable and their individual wished were followed and people were happy with the prompt answering of the call bells. We saw that recommendations made in the report had been actioned individually with people.

A staff survey had been undertaken in November 2016 the results of which demonstrated that staff felt confident to raise concerns/incidents and mistakes. The survey identified staff felt they were treated equally and felt confident that residents were treated with kindness and compassion.

The acting manager told us it was their intention to develop surveys and distribute them to visiting healthcare professionals in an attempt to obtain feedback about the quality of the service being delivered. We were told that once these had been returned it was their intention to analysis the results and produce a short report.

Since the last inspection we saw the policies and procedures had been reviewed and updated and were accessible to staff. This meant that staff had access to up to date good practice guidance.

We were told and staff confirmed that a general staff meeting had been held in February 2017 although the minutes could not found during the inspection. The acting manager said it was their intention to implement formal staff meetings each month with a maximum of six staff in attendance at a time rather than have large general meetings.

Part of a registered manager's or registered provider's responsibility under their registration with the Care Quality Commission (CQC) is to have regard to, read, and consider guidance in relation to the regulated activities they provide, as it will assist them to understand what they need to do to meet the regulations. One of these regulations relates to the registered managers/registered provider's responsibility to notify us of certain events or information. We checked our records before the inspection and saw that accidents and incidents that CQC needed to be informed about had been notified to us by the registered manager.

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 17 HSCA RA Regulations 2014 Good governance Systems to monitor the safety and quality of the service were not effective at ensuring full compliance with the regulations. The registered provider had failed to ensure accurate, complete and contemporaneous records in respect to each service user. Regulation 17(1) (2) (c)