Richmond Court Nursing Home Limited

Richmond Court Nursing 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?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Richmond Court Nursing Home is a care home which provides personal care and nursing for up to 39 people, including people with dementia. At the time of our inspection there were 30 people using the service.

People's experience of using this service and what we found
People were not always protected from the risk of harm. We found systems were not effective in assessing and monitoring risks to people through their dietary needs, the spread of infection or the safe storage of medicines. Systems were in place to safeguard people from abuse, although people didn't always feel safe. Processes for learning lessons were effective and improvements were noted as a result.
People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

People were not always treated in a compassionate, respectful way. Some people experienced inconsistencies in the caring nature of staff members. The service considered people's cultural needs and wishes. People were supported to express their views and be involved in their care, although people didn't always feel this was effective.

People's care plans did not always contain accurate information about their person-centred needs. However, staff had good knowledge of people's likes and dislikes and people were given day to day choices. People who were cared for in bed did not always have access to meaningful activities, although a full program of group activities took place in communal areas.

Quality assurance systems were not always effective for people. This meant the action taken by the provider had not always ensured people received consistent, good quality and safe care. However, people and relatives spoke positively about the management of the service. Systems were in place to seek feedback and resolve people's complaints.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was requires improvement (published 20 November 2019).

Why we inspected
The inspection was prompted in part due to concerns received about how people's health and personal care needs were managed. We also received information from health professionals about shortfalls that had been identified in relation to nutrition and hydration, the monitoring of people's health needs and the management of the service. A decision was made for us to inspect and examine those risks.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

Enforcement
We have identified breaches in relation to how people's safety was managed, how people's rights were promoted, people being treated with dignity and respect and how the service was run at this inspection.

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

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not always safe. Details are in our safe findings below.	**Requires Improvement**
Is the service effective? The service was not always effective. Details are in our effective findings below.	**Requires Improvement**
Is the service caring? The service was not always caring. Details are in our caring findings below.	**Requires Improvement**
Is the service responsive? The service was not always responsive. Details are in our responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our well-led findings below.	**Inadequate**

Richmond Court Nursing Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

Inspection team
This inspection was carried out by 1 inspector and a nurse specialist advisor.

Service and service type
Richmond Court Nursing Home is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Richmond Court Nursing Home is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was not a registered manager in post. A new manager had been in post for 2 months at the time of the inspection and intended to register with CQC. Since the inspection, the manager has now been registered with us.

Notice of inspection

This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke to 8 people and 6 relatives about their experience of the care provided. We spoke with 5 professionals who have contact with the service. We spoke with 11 members of staff including the nominated individual, area manager, manager, and 8 members of staff. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We reviewed a range of records. This included 6 people's care plans, medicine administration records (MAR) and 3 staff recruitment files. We viewed a variety of records relating to the management of the service including audit systems.

Requires Improvement

Is the service safe?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management; Using medicines safely; Preventing and controlling infection

● Risks to people's individual nutritional needs were not adequately assessed, documented and managed safely. Contradictory and inaccurate information was recorded in care plans about some people's specific dietary needs. Staff knowledge and understanding of people's individual dietary needs, including modified textures of food, was inconsistent. This meant we could not be assured people had been receiving meals in line with their assessed needs; this put people at risk of harm.

● People at risk of losing weight were not always suitably supported. During our inspection, kitchen staff advised us, and documents recorded, that there were not any people who required fortified foods. This is where calories are added to meals to support people at risk of weight loss. Following the inspection, the manager reviewed people's dietary needs including modified textured diets and fortified diets. This highlighted several people were at risk of losing weight and discrepancies in previous documentation about people's dietary requirements.

● Monitoring of people's diet and fluid intake was not robust. There was not a clear system in place to ensure people's intake was overseen over more than 24hrs. This meant decreased dietary or fluid intake over several days may not have been identified.

● Medicines and medical equipment was not always safely stored. On the first day of our inspection, we found a sharps box (containing lancets, which are sharp items use to prick the skin) and people's prescribed creams and supplement drinks left unattended in the dining room. This put people at risk through contact with sharp items or creams which were not prescribed for their use.

● We were not assured the provider was promoting safety through the hygiene practices of the staff and premises. For example, we observed medical equipment and furniture that was visibly soiled. Staff were observed wearing jewellery when supporting people. This put people at risk of harm through the spread of infection.

There was a failure to protect people with robust monitoring and management of risks, safe storage of medicines and infection control measures. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

● People received their medications as prescribed. Time specific medications and variable doses of medications were recorded clearly and administered as prescribed.

● People with diabetes were supported in line with their needs. People had care plans in place to document their individual needs. Records showed people had their blood sugar monitored and received their

medication as prescribed.

Visiting in care homes
The provider was facilitating visits for people living in the home in accordance with current guidance.

Systems and processes to safeguard people from the risk of abuse
● We received mixed feedback from people and relatives about whether people at Richmond Court Nursing Home were safe. When asked if their loved ones were safe, some relatives were hesitant to answer. One family member said, "I'm not really sure, to be truthful."
● Staff received safeguarding training and understood the signs of abuse and how to report any concerns they may have.
● Systems were in place to identify, report and investigate any safeguarding risks to people. Incidents were recorded and referred to the Local Authority safeguarding team where appropriate.

Staffing and recruitment
● Staffing levels were maintained at a suitable level to support people safely. We observed staff were available throughout the home and people received support with their needs in a timely way. However, some nursing staff were not always knowledgeable and confident supporting some people with clinical care.
● Staff files showed the staff members had been recruited appropriately. The provider had completed past employment and police checks before the staff members started at the service to make sure they were suitable to work with people.

Learning lessons when things go wrong
● Systems were in place to review accidents and incidents and identify any learning. Records showed the new manager had improved the quality and detail of this analysis. Any actions identified were recorded and updated when completed.
● Staff displayed an openness about improvements needed at Richmond Court Nursing Home and a willingness to embrace change. One staff member told us, "We are human, we all make mistakes. But we need to learn from our mistakes. Things have started to change."

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Ensuring consent to care and treatment in line with law and guidance
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 MCA 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 to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

- People's capacity to consent or best interests regarding restrictions imposed by the provider weren't always considered and documented. We found inconsistencies in how decisions regarding bed rails were recorded for people who may lack capacity to consent to their use.
- Capacity assessments weren't always specific to the decision being made, at the time the decision was required. We found some capacity assessments contained a memory test document, which did not have any bearing on the specific decision required.
- Systems were in place to seek DoLS authorisations for people at risk of being deprived of their liberty. However, records were not kept of how the provider was meeting conditions placed on 1 person's authorisation. This meant, we could not be assured the person was being supported in the least restrictive way, in their best interests.
- Systems were not in place to ensure consent or best interest decisions were reviewed in light of changes. We found decisions made in a person's best interest had not been revisited when a person regained capacity, to ensure they were in line with the person's wishes and values.

The provider had failed to ensure people's rights were protected. This was a breach of Regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to eat and drink enough to maintain a balanced diet

● People weren't always provided with enough food to satisfy them. We observed that lunch portions were small. People and some relatives also reported this. One person, who was at risk of weight loss, was heard saying about their lunch, "Is that it?" After lunch, we asked the same person if they had had enough to eat. They told us that they hadn't. A relative of another person commented, "[My family member] had said that the meals are small. [My loved one] hardly eats anything, so to comment on the meals being small, it's a bit worrying."

● People told us they had been asked about their likes and dislikes and could choose the meal they preferred. Staff had good knowledge about people's preferences and people were offered cultural food choices.

Adapting service, design, decoration to meet people's needs

● The environment was showing some signs of wear and tear. The provider was aware of this and actions were ongoing to update the interior. A professional who regularly visited the service told us that they had seen improvements in the aesthetics and layout of communal areas.

● The environment had been adapted to support people's individual needs. For example, bathroom doors had multilingual signs to support people's orientation. People's rooms were personalised.

Staff support: induction, training, skills and experience

● We received mixed feedback from professionals about their confidence in the skills of staff. For example, some professionals had concerns about the knowledge of the nursing staff about basic health needs. However, others reported that the staff team knew people well, including their health needs and medical treatment.

● Staff received an induction and training. Staff told us the training provided was effective. There were some gaps in training such as safeguarding and nutrition, however this had been identified by the provider and was being addressed.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care

● Systems in place to manage people's skin care weren't always effective. We observed gaps in records that assessed people's risks and recorded skin care, such as the administering of creams. Professionals reported, and our inspection highlighted, that not all nursing staff had the knowledge and confidence to manage people's wounds. The provider was receiving external support in this area.

● Records showed people's weights were monitored appropriately by the service. Where patterns of weight loss were apparent, the manager took action to seek guidance from appropriate professionals.

● Community matrons accessed the home regularly to support the home to meet people's health needs. They reported a significant improvement in the overall service people receive since the new manager had been in post.

● The provider worked with external agencies to ensure people received treatment as required. Records showed professionals were consulted and referrals were made when appropriate. People were supported with regular appointments such as seeing an optician.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity; Respecting and promoting people's privacy, dignity and independence

- People and relatives told us there were inconsistencies in the caring attitude of some staff. One person said, "There is the odd one or two [staff] that I wouldn't give a good name to." A relative told us there were some staff members they didn't find approachable, with one staff member being abrupt when asked for help. They said, "We don't bother asking [the staff member] anymore."
- People's records weren't always written in a respectful way. We observed that some entries in care plans were based on judgement rather than factual information. This compromised people's dignity.
- People's privacy wasn't always upheld. For example, we observed people being transferred from a chair using a hoist, in a way that didn't protect their dignity.
- Staff members were observed using language that didn't uphold people's dignity. Whilst these were light-hearted interactions with people, it fell short of respectful communication. For example, we saw a staff member shout across a room to get a person's attention.

People did not always receive compassionate care that upheld their dignity. This was a breach of regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Whilst there were inconsistencies in the caring approach of staff, we observed many compassionate interactions between staff and people. For example, staff were always seen offering reassurance to people who were being transferred using a hoist. One relative said, "The environment in basic, but the care; we wouldn't get it in a 5 star home."

Supporting people to express their views and be involved in making decisions about their care

- There was a system in place for reviewing care plans. However, we received mixed feedback from people and relatives about whether they had seen their care plans or been involved in reviews. Some people and relatives reported being involved and updated, while others said they hadn't taken part in any discussions.
- The new manager was in the process of setting up processes for people to feedback about the service and their experiences. Records showed the manager conducted a daily walkaround where people were asked about their views and concerns.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At our last inspection we rated this key question requires improvement. The rating for this key question has remained requires improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- People's care plans and risk assessments weren't always accurate, consistent and up to date. The provider was aware of this issue and had been auditing people's care plans to identify where improvements were needed.
- Staff were knowledgeable about people's likes, dislikes, needs and histories. Care plans included a life story book, although these weren't consistently completed for people. Audits showed these gaps had been identified by the provider and were part of their improvement action plan.
- People were supported to make day to day choices. One person told us, "I choose when I get up, I choose when I go to bed. I do choose, it's never any problem."

Meeting people's communication needs
Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

- People had communication care plans in place that considered their individual needs. However, further consideration could be given to supporting communication for people with dementia. For example, picture menus weren't always fully representative of the choices on offer.
- People with first languages other than English were supported by staff who knew their language and could communicate with them. Documents such as the complaints procedure were available in different languages.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- People who were cared for in bed spent large periods of time alone. Whilst the activity coordinator spent time with people in their rooms, there were gaps in records which only stated 'room visit'; it was unclear how this met people's person-centred needs.
- One relative told us time alone had resulted in a negative impact on their loved one. They said, "People are sat in their own rooms with their own thoughts. It's not good for anyone. If they put me in a room with my own thoughts, I'd go backwards too."
- People were supported by an activity coordinator who took an active role at the service and provided a range of activities for people in the communal areas. People had a good rapport with the activities

coordinator and we saw people enjoying a range of games and pastimes.

Improving care quality in response to complaints or concerns

● The home had previously used a complaints book to record concerns they received and brief details of how these matters were addressed. However, there was no record of how the complaints had been investigated. The provider showed us that a robust system for recording and investigating complaints was available and the manager expressed a commitment to using this process going forward.

End of life care and support

● People had care plans to consider their individual wishes, values and beliefs at the end of their lives. People had FREED (Frailty, recognising end of life and escalating deterioration) care plans to consider their individual needs.

● Staff had received FREED training, to support them to access support and make referrals for people who may be experiencing a deterioration in their health.

Inadequate

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question requires improvement. The rating for this key question has changed to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- Quality assurance systems had failed to identify the areas of concern we highlighted during our inspection. Audits had not been effective in finding the issues we established in relation to the safety and quality of the service people received.
- The provider's processes had not ensured care plans, risk assessments and daily records were consistently reviewed and updated to provide key information about people's needs. This included the issues we identified relating to people's dietary needs, mental capacity and personal care needs. The provider was aware of a general shortfall in the quality of recording and was in the process of making improvements.
- Clinical oversight processes were not robust. Systems for monitoring people's fluid balance, nutritional intake or skin care needs were not effective. There were no systems or processes in place to maintain consistent oversight of these key aspects of people's clinical care.
- Audit systems were not effective in identifying shortfalls in compassionate, caring staff practice. This included both how people were interacted with and how people's information was documented in care records.
- This is the second consecutive inspection where Richmond Court Nursing Home has been rated requires improvement.

The provider had failed to implement effective systems and processes to drive the quality and safety of the service. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

- We received mixed feedback from professionals about how well the provider communicated with them. One professional told us, "I do have my reservations as to the effectiveness of the communication within the nursing staff, how information is shared and their handover of residents to other staff."
- Staff spoke positively about their roles and the people they worked with. One staff member said, "I always enjoy it; I wouldn't change my job. I love it here."
- Systems were established to seek feedback from people, family and visitors to the service. We saw previous feedback had been analysed and was positive about the service people received.

Continuous learning and improving care

● The provider had an ongoing improvement action plan in place and had been working closely with external professionals to improve the service. Professionals we spoke with reported the service had engaged well with them and they had seen positive change.

● People, relatives, staff and professionals were universally positive about the new manager and had confidence that they would continue to improve the service. One professional stated, "I am impressed with the changes. [The manager] is magnificent! Things have changed massively."

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

● The manager had a clear understanding of duty of candour and their statutory responsibilities to notify CQC of certain incidents and events.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect
Treatment of disease, disorder or injury	People did not always receive compassionate care that upheld their dignity. This was a breach of regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

Warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent
Treatment of disease, disorder or injury	The provider had failed to ensure people's rights were protected. This was a breach of Regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

Warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	There was a failure to protect people with robust monitoring and management of risks, safe storage of medicines and infection control measures. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

The enforcement action we took:

Warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or	Regulation 17 HSCA RA Regulations 2014 Good

personal care

Treatment of disease, disorder or injury

governance

The provider had failed to implement effective systems and processes to drive the quality and safety of the service. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

Warning notice