Richmond Villages Operations Limited

Richmond Village Wood Norton

Inspection report

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Date of inspection visit:
31 January 2023
02 February 2023

Date of publication:
14 April 2023

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

Richmond Village Wood Norton is a purpose-built residential care home providing personal and nursing care to up to 60 people. The service provides support to younger and older people and people with dementia. At the time of our inspection there were 50 people using the service.

Richmond Village Wood Norton accommodates people in an adapted building that is part of a retirement community.

People's experience of using this service and what we found
The governance systems were not effective in identifying and addressing the issues we found at this inspection in relation to safety and failing to inform CQC of notifiable events.

Relatives shared mixed views about the leadership of the home. Some felt communication was poor and improvements were needed. Others felt they were kept informed about their family members health and wellbeing.

People's medicines were managed safely, staff had received training and their competencies assessed.

People told us they were treated kindly by staff and their privacy was respected. Risks to people had been assessed and recorded so staff knew how to keep them safe.

People and their relatives were regularly given the opportunity to provide feedback about the service through the completion of surveys and meetings.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

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 good (published 19 May 2021).

Why we inspected
The inspection was prompted in part due to concerns received about standard of care and failure to report concerns. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

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.

The overall rating for the service has changed from good to requires improvement based on the findings of this inspection.

We have found evidence that the provider needs to make improvements. Please see the safe and well led sections of this full report. We are assured the registered manager has taken some action following the inspection to address our concerns.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Richmond Village Wood Norton on our website at www.cqc.org.uk.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

Follow up
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 well-led? The service was not always well-led. Details are in our well-led findings below.	**Requires Improvement**

Care Quality Commission

Richmond Village Wood Norton

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.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection team consisted of 2 inspectors and a specialist advisor in nursing.

Service and service type
Richmond Village Wood Norton is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under 1 contractual agreement dependent on their registration with us. Richmond Village Wood Norton 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 a registered manager in post.

Notice of inspection
This inspection was unannounced on the first day. We announced our intention to return to the home for the second day of the inspection.

Inspection activity started on 31 January 2023 and ended on 22 February 2023. We visited the location's service on 31 January 2023 and 2 February 2023.

What we did before the inspection
We reviewed information we had received about the service. We sought feedback from the local authority and Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.
The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make.

We used all this information to plan our inspection.

During the inspection
We spoke with 9 people living at the home and 8 relatives about their experience of the care provided. We spoke with 13 members of staff including the registered manager, village manager, nurses, carers, auxiliary staff and the nominated Individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We also spoke with a health care professional who regularly visits the service.

We looked at 5 people's care and medication records, handovers, staff files and training records. After the inspection site visit, we reviewed further records relating to the safety, quality and management of the service.

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

- Risks relating to the safety of the environment were not always managed well. There had been a previous incident where a window restrictor had not prevented a person exiting the home through a window. Whilst no harm came to the person the provider did not take the opportunity to either change the type of window security fastenings, or to consider wider risks to other people in relation to potential failure of window restrictors. We discussed this with the registered manager during our inspection. The provider took immediate action to ensure windows were fitted with additional restrictors.
- Staff we spoke with understood what action they would need to take in the event of a fire to keep people safe. However, from September 2021 to September 2022 not all staff had attended a fire drill, in line with the providers own risk assessment. This placed people at risk. After the inspection the provider gave us their assurances that staff are appropriately trained.
- Other aspects of fire safety and the environment were assessed and managed well. For example, regular fire checks were carried out, equipment was regularly checked and maintained.
- Risks to people were assessed, recorded, and regularly reviewed. One person was assessed by the speech and language therapy team and identified as being at risk of choking. Staff were aware of the persons needs and the support they required.

Staffing and recruitment

- Whilst there were enough staff deployed to meet people's needs in a timely way, we received mixed feedback in relation to staffing. One person told us, "They [staff] can take a bit longer at night." However, one relative told us, "There are plenty of staff around and there are extras to carers, like the activity staff."
- Staffing numbers were determined using a dependency tool. This is used by some services to determine the minimum staffing levels required.
- The provider had processes in place to ensure staff were recruited and inducted safely. However, some evidence of pre-employment checks was missing. The registered manager was made aware and prompt action was taken to address this.

Preventing and controlling infection

- Care home staff are no longer required to routinely wear face masks. Some staff had chosen to continue to wear a face covering. We observed some of the staff wearing masks incorrectly. We gave feedback to the registered manager. When we returned, we saw masks were being worn correctly.
- We were assured that the provider was preventing visitors from catching and spreading infections.

● We were assured that the provider was supporting people living at the service to minimise the spread of infection.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was responding effectively to risks and signs of infection.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.

Visiting in care homes
● We saw people receiving visitors throughout the inspection. Relatives told us they were able to visit without any restrictions.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong
● People were protected from the risk of abuse or harm.
● People were supported by staff who understood their responsibilities to report safeguarding concerns. One relative told us, "I know [Person's name] is safe, they keep a constant eye on them."
● Staff were confident in approaching the registered manager to raise concerns.
● The provider had safeguarding policies in place for staff to follow.
● Accidents and incidents were recorded and analysed by the registered manager. This helped to identify actions that could be taken to reduce the risk of the incident occurring again. For example, an identified increase in falls had resulted in additional falls detection equipment being ordered to ensure there was enough equipment available as people's needs changed or new people moved in.

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 Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)
● We found the service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty. Any conditions related to DoLS authorisations were being met.

Using medicines safely
● People received their medicines safely.
● Regular checks were carried out on people's medicines to make sure they were being administered in line with best practice and to identify any errors. Where errors had been identified, appropriate actions were taken.
● Where people were prescribed "as and when" medicines, guidance was in place to support staff in safe administration.
● Staff who were responsible for the administration of medicines had received training and their competencies assessed.

Requires Improvement

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 good. At this inspection the rating has changed to requires improvement.

This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- Systems to monitor the quality and safety of the service were not always effective.
- Safety checks carried out by the provider had not always identified or promptly driven through improvements required to reduce risks to people following near misses. In addition, governance checks had not consistently identified and addressed risks relating to the storage of thickeners and other items which may be harmful to people if ingested. The provider was made aware and took action to address the concerns raised.
- We identified occasions where the provider had failed to notify CQC of incidents. This was discussed with the provider and the notifications were submitted retrospectively. However, following the inspection, we found additional notifications had not been submitted to us.
- The registered manager and provider audits had not identified some of the concerns we identified during the inspection for example in relation to risk management including, gaps in records, storage of items that may be harmful to people if ingested.
- A range of audits were completed by the provider, registered manager and staff. These provided information to support the monitoring of the home.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- We received mixed feedback in relation to how the service was run. One relative said, "There is a friendly atmosphere, and everyone is positive." Other relatives felt the service did not always fully involve them. For example, changes to their family members care needs were not always discussed with them.
- People were offered choices and supported in a kind and compassionate way. One person told us, "I didn't want to move here but I'm glad I did, I am happy, and the staff are lovely."
- Staff told us they felt supported in their role and were clear about their responsibilities.
- Staff had various channels to provide feedback or raise concerns, for example staff meetings, or confidentially through the speak up service. Daily handovers ensured important information was shared about people.

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

● Systems in place to record, respond and manage complaints were not always effective.
● Most relatives we spoke with said they had not had the need to raise a complaint. However, some relatives told us they had raised either a concern or complaint and these had not been responded to.
● The registered manager understood their responsibilities under the duty of candour to be open, honest and apologise when things had gone wrong.
● We spoke with a relative who's family member had been involved in an incident at the home. They told us how they had been kept informed and offered an apology. They were satisfied with the actions taken.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● People, relatives and staff were given the opportunity to provide feedback about the service through regular surveys. The provider was able to analyse the data collated and see where the service needed to make improvements.
● Most relatives told us they were kept informed by staff about their family member.

Continuous learning and improving care
● The registered manager completed a monthly quality report providing information for the provider to review.
● The provider visited the service regularly to speak to people and staff and complete quality assurance reviews. This helped to identify any improvements required.
● The registered manager and provider responded to the concerns raised during the inspection and took immediate action to start addressing issues we had identified.

Working in partnership with others
● The service worked with external partners, including external health care professionals and the local authority. This helped to ensure people receive the health care support they needed.
● Referrals were made to external health care professionals when required. One professional told us, "People seem well looked after and happy. The staff have a good insight into people's needs."