Richmond Villages Operations Limited

Richmond Village Aston On Trent Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Richmond Village Aston On Trent Care Home is a residential care home providing personal and nursing care to 61 people. At the time of our inspection there were 26 people living at the home. The home is part of a retirement village which included access to spa and leisure facilities, a restaurant, and gardens. Within the home care is provided across two floors and there were communal rooms on each floor.

People's experience of using this service and what we found
People did not always receive safe care because risk was not always managed effectively, and lessons were not always learnt when things went wrong. There were not always enough experienced staff deployed in all areas of the home to meet people's needs promptly and to ensure their dignity. People were not always supported to have maximum choice and control of their lives and staff weren't always able to support them in the least restrictive way possible and in their best interests. The policies and systems in the service supported this practice and we made a recommendation to fully implement them.

There was a new management team in place who were reviewing the systems and implementing change. However, we found improvements were required to fully embed management systems to achieve good outcomes for people.

Regular staff knew people well and understood their preferences. There were lots of opportunities for people to engage them in meaningful activities, including through working with other organisations. Care plans were informative and regularly reviewed to support them. People were supported to maintain good health and nutrition.

The new manager was approachable and there were meetings in place which encouraged people and staff to give their feedback. People and relatives knew how to raise a concern or make a complaint. The environment was adapted to meet people's needs.

More information is in the full report.

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

Rating at last inspection and update: The last rating for this service was requires improvement (published 9 October 2018). The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection enough improvement had not been sustained and the provider was still in breach of regulations. The service remains rated requires improvement and has now been rated requires improvement for two consecutive inspections.

Why we inspected
This was a planned inspection based on the previous rating.

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

Enforcement
We have identified breaches in relation to safe care and treatment, staffing and good governance at this inspection.

Please see the action we have told the provider to take at the end of this report.

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 return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our caring findings below.

Is the service responsive?

Good

The service was responsive.

Details are in our responsive findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-Led findings below.

Richmond Village Aston On Trent Care 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 Care Act 2014.

Inspection team
The inspection was completed by one inspector, one assistant inspector and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Richmond Village Aston On Trent Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service did not have a manager registered with the Care Quality Commission; however, they did have a newly appointed manager who was in the process of completing their registration. When a registered manager is in place this means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We used information we held about the home which included notifications that they sent us to plan this

inspection. We also used the completed Provider Information Return (PIR). This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We also contacted the local authority contracts management team for feedback from their reviews of the service. We used all of this information to plan our inspection.

During the inspection
We spoke with nine people who used the service and four visiting relatives about their experience of the care provided. We spoke with twelve members of staff including the manager and other managers including ones with responsibility for training and clinical governance. We also spoke with the clinical lead, a nurse, senior carers, carers and two domestic staff. We spoke with one visiting health and social care professional.
We reviewed a range of records. These included seven people's care records and multiple medication records. We looked at a variety of records relating to the management of the service and reviewed some audits.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at falls management and medicines administration.

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 the last inspection this key question was rated as Requires Improvement. At this inspection this key question has remained the same. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was a risk that people could be harmed.

Assessing risk, safety monitoring and management; Using medicines safely; Learning lessons when things go wrong
At our last inspection the provider had failed to robustly assess the risks relating to the health safety and welfare of people. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection this had improved, and some risks previously identified were managed; however, there were further improvements required to ensure that all risks were assessed and managed and they remained in breach of regulation.
• Medicine management had improved to reduce the risks associated with them and people told us they mostly had them as prescribed. However, some people told us of errors which occurred when there were temporary staff administering their medicines. The new manager and clinical lead had implemented daily monitoring systems to reduce the risk of this occurring again and provided more detailed handover information for newer staff.
• Some systems which were in place to record topical medicines administration were complex and repetitive. One relative told us this made it difficult for them to check on their relative's welfare to ensure creams had been administered.
• Other assessments were not always in place. For example, when one person had sore skin they did not have a plan to manage this recorded and widely shared. Although their skin was monitored and reviewed it meant important information was not widely shared with all staff; for example, they should not have rested on their back to protect their skin from further damage and this information was not easily available to care staff. We found records which showed they had been moved to their back. This meant the person was exposed to harm because information about how to protect them was not shared effectively.
• Some people were living with dementia. At times they behaved in a way which could cause themselves or others harm; for example, one person demonstrated distress when they were assisted with personal care. There was limited information available to staff to guide them to support people consistently during these episodes of distress. Staff and relatives described how some people required additional staff support at times. This meant they were not available to support others in a timely manner.
• Lessons were not always learnt when things went wrong. For example, the action after one accident was for one person to have staff supervision when they were in their wheelchair. We observed this did not always happen, which put the person at increased risk of harm through another accident.

We found no evidence that people had been harmed; however, systems were not robust enough to demonstrate safety was effectively managed. This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Other risk management was good. There were now clear plans in place around specialist diets some people required to avoid choking.
• People were supported to move in line with their care plans and we observed safe moving using equipment.
• There was improved guidance in place when people were prescribed to take medicines 'as required' and when medicine was given covertly. People can be given medicines covertly, or without their knowledge, when it has been assessed as being in their best interest with medical professional guidance. This was now in place.

Staffing and recruitment
• At our last inspection we found there were not always sufficient qualified, skilled staff deployed to meet people's needs safely. At this inspection this continued to be the case.
• Staffing was planned around individual need and we found this was enough on one floor. However, on the other floor staff and relatives told us they did not feel the dependency and complexity of some people's needs had been fully accounted for. We observed people without support from staff several times throughout the inspection visit. On one occasion we had to intervene between two people and call for staff assistance.
• Relatives told us there were other times when staff were unavailable. One relative said, "When all of the staff are needed to support some people it leaves the whole of the floor empty. Sometimes we feel like we are looking after people instead."
• People did not always feel safe when there were temporary staff supporting them. One person said, "They employ too many agency staff and there's no consistency of care. It does affect the quality of care."
• Relatives told us that some people living with dementia were affected by changes and that new staff didn't know them as well. One relative said, "They had a regular 'team' for a while and that helped but now there are lots of new faces again and they don't know how to support people." Another relative said, "There's no consistency of care. The different carers don't know [Name] and when strangers come in they don't know their likes and dislikes."

Although the provider had taken action to improve the deployment of staff in some areas of the home we found this was not consistently managed across all of the home. This was a breach of regulation 18 (1) (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Safe recruitment procedures were followed to ensure staff were safe to work with people. One member of staff said, "They checked all of my employment history for the past two years and asked me for an explanation for any gaps in my employment history."

Systems and processes to safeguard people from the risk of abuse
• Staff were knowledgeable about safeguarding and could explain the processes to follow if they had concerns.
• When safeguarding concerns were raised and investigated action was taken to protect people from further harm.

Preventing and controlling infection
• The home continued to be clean and hygienic which reduced the risk of infection.
• There were staff available to clean the home and people's bedrooms.
Staff wore personal protective equipment when they were supporting people to reduce the risks of spreading infection.
• Regular reviews and audits were completed to ensure the home remained clean.

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 the last inspection this key question was rated as Requires Improvement. At this inspection this key question has remained the same. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

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 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 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, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.
• People told us they were included in decisions. One person said, "Most of the staff know me and once I've told them about my preferences they follow them." They told us, and we heard they were asked for their consent before they were supported by staff.
• However, when people were not able to make their own decisions there were not always capacity assessments for this or to show how best interest decisions had been made. For example, one member of staff told us a decision had been made by the person's doctor and it was unclear whether they or their family had been included in this. Other decisions had been clearly assessed.
• When DoLS had been approved staff were aware and any conditions were met.
We recommend that assessments are consistently applied to all decisions when people don't have the capacity to make decisions in line with the MCA.

Staff support: induction, training, skills and experience
• People were happy with the skills of regular staff. They told us they felt confident with them. One relative said, "The staff know [Name's] needs and they are well trained."
• Staff told us they were provided with training and developmental opportunities; for example, training to become a senior carer. They were also supported through regular appraisal meetings.
• However, some staff told us they would like more specialist training particularly in supporting people living with dementia. They also felt they didn't always have the opportunity to put the training into practise; for example, being moved across different floors prevented them building important relationships with people.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live

healthier lives, access healthcare services and support
• People told us they were supported to see medical professionals when required. They also said they were confident in the regular nursing staff in the home. However, some said this was less certain when agency staff were employed. For example, one person told us they were unhappy about how a medical test had been conducted.
• Healthcare staff we spoke with told us they visited on a weekly basis. Healthcare staff we spoke with told us they visited on a weekly basis. This gave people the opportunity to have their health reviewed on a regular basis.

Supporting people to eat and drink enough to maintain a balanced diet
• People were supported to have balanced diets and their weight was regularly monitored to ensure they had enough to eat.
• There was a choice of meals available and people were offered a choice.
• Most people were positive about the food they were offered. Some people had suggestions about improvements and we saw they were provided with a feedback card to complete. For example, one person wrote they didn't enjoy a meal and would order the other option in future.
• Special diets were catered for and this included softened or puree food for people who were at risk of choking. This was presented well to stimulate people's appetites.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
• People's needs and choices were met in line with national guidance and best practice.
• Their care plans contained detailed information to support specific health conditions, dietary requirements and mental health support needs. Staff we spoke with understood people's assessments. For example, one member of staff said, "We have been promoting people's oral health and encouraging them to brush their teeth. We know the signs to look out for such as bleeding gums."

Adapting service, design, decoration to meet people's needs
• The building had been designed to meet the needs of the people who lived there. For example, there were wide corridors and doorways for people using mobility aids.
• People's bedrooms were personally designed, and they had personal items in them.
• There was clear signage throughout the building to assist people to find their way round.
• There were several lounges and plenty of space for people to engage in activities and move around freely.
• There were other facilities in the 'village' which people could use at their leisure, including a gym and a restaurant.

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 the last inspection this key question was rated as requires improvement and at this inspection remained the same. 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 did not always have their dignity upheld. For example, one member of staff supported two people to eat at the same time. This meant they were not focussed on an individual and ensuring people had a pleasant mealtime experience.
• At other times, people were not comforted when they were distressed because there were no staff available in communal spaces. For example, one person was touching another and speaking with them, but it caused the other person distress. There were no staff available to intervene and diffuse the situation.
• People we spoke with told us they did not always feel temporary staff cared for them in the same way as permanent, familiar ones; for example, one person told us some staff could be abrupt. However, they also said, "The permanent staff know me well and we laugh and joke."
• When staff were present and had more time we observed caring interaction. One person told us how they preferred to spend time in their room. They said, "The staff pop their heads in just to say hello and check in on me; they are lovely."
• Staff we spoke with told us they enjoyed their work, but some did say they found it difficult to provide the person-centred care they wanted to when they were busy.

Supporting people to express their views and be involved in making decisions about their care
• People were able to make decisions about their care; for example, some people still had some involvement in managing their medicines.
• Some people were less able to express their choices verbally, but regular staff knew them well and could understand what they wanted. For example, they understood when people had become tired and wanted to rest.
• The 'village' location enabled some people to retain independence within a safe environment. People were able to come and go as they wanted and take part in other aspects of 'village' life.
• Some relatives lived other areas of the 'village' and they shared how convenient this was to enable them to visit their loved ones at any time.
• Other family members were also welcomed when they visited and told us they had good relationships with the regular staff they saw.

Good

Is the service responsive?

Our findings

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

At the last inspection this key question was rated as Good. At this inspection this key question has now remained the same. This meant people's needs were met through good organisation and delivery.

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
• Activities were planned with people to ensure they were engaged and interested.
• There were group activities arranged and staff dedicated to organising leisure and social engagements for people. Some of this happened on an individual basis; for example, one person who had been depressed was encouraged to take part gradually in exercise and now they felt more motivated and regularly used the gym.
• Some people used the 'village' facilities including the gym, spa and swimming pool. There were also exercise classes organised in communal rooms in the care homes.
• People also told us they valued the additional facilities and often went to coffee mornings etc in the 'village'.
• The activities staff had training and equipment to support people living with dementia to engage and reminisce.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences
• People were supported by staff who knew them well and understood their preferences. Staff we spoke with could explain how they cared for each person in detail and anybody they felt needed closer monitoring.
• People had care plans which were personalised and detailed. They were regularly reviewed and updated.
• Staff told us they met regularly to discuss what support people required. One member of staff said, "We have a handover every day to find out about people's needs."

Meeting people's communication needs
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.
• People's communication needs were assessed, and it was clear how information should be shared with them.
• There was information displayed in the home in pictures and symbols so that those people who were no longer able to read could understand it.

Improving care quality in response to complaints or concerns
• People knew how to make complaints and felt they would be listened to.
• There was a complaints procedure in place which was shared with people and on noticeboards in the

home.
• Any complaints received were managed in line with the provider's procedure.

End of life care and support
• People's wishes about the care they would like at the end of their lives had been discussed and recorded. For example, people's choices about whether they wanted to be actively resuscitated were recorded.
• Nursing staff were trained to administer end of life pain relief and worked closely with other professionals to ensure peoples preferences were met.

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 the last inspection this key question was rated as Requires Improvement. At this inspection this key question has now remained the same. 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.

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

• There had been changes in the management team and a high turnover in staff since the last inspection. This had impacted the quality and consistency of care people received. At this inspection there was a new manager, a new clinical lead and a new village manager. Some interim leadership had also been provided by quality and dementia leads. Although there were clear plans in place to improve the service there continued to be areas for improvement.

• People and some relatives told us about concerns they had for their or their family member's safety. They described medicines errors and falls. When we tried to review these incidents, the manager was unable to locate records about some of them. This meant systems which should have protected people from harm were not being followed. Although the manager assured us of the systems and safeguards which were currently being implemented, some of these incidents were recent and with current staff. Therefore, we were not assured that all staff followed management systems to ensure people were safe.

• Concerns continued to be raised about staffing levels. Although they had been increased in some areas of the home, both relatives and staff told us there was still a considerable impact on the quality of people's lives in another area. Some staff felt the complexity of people's needs was not fully assessed. Families also shared concerns about inconsistency of staff and the impact this had on people living with dementia. Although the manager was reviewing staffing and in the process of a re-structure consultation, we had highlighted concerns around staffing at the previous inspection and therefore the provider had not demonstrated timely action.

• Although we found some improvements, particularly in some areas of risk and medicines management, other areas still required improvement to ensure systems were effectively implemented to achieve good outcomes for people. For example, ensuring information to protect people decided in weekly clinical meetings is cascaded through care plans and daily monitoring. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service has been rated as requires improvement for one previous inspection and at this inspection we found they were in breach of regulations and the overall rating for this service is Requires Improvement again. Providers should be aiming to achieve and sustain a rating of 'Good' or 'Outstanding'. Good care is the minimum that people receiving services should expect and deserve to receive.

We will ask the provider to give us information about how they plan to improve the quality and safety of the

service and the experience of people using it under Regulation 17(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We will also be meeting with the provider to review what changes will be made to ensure that outcomes for people who use the service improve.

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
• There was not a registered manager in post, but a new manager had commenced and was pursuing their registration. They had spent time in the home prior to starting full time to get to know people. People and relatives spoke positively about this approach. One person said, "I can speak with them, they are often around."
• When we shared some of the concerns people had raised with us the manager followed up after the inspection visit. They gave us feedback about the meetings they had with people and the responses and assurances they had given them about moving forward.
• We had received notifications about important events so that we could check that appropriate action had been taken.
• The previous rating of the home was displayed in line with our requirements.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
• There were regular meetings with staff and people who lived at the service. These included meetings with catering and activity staff to ensure people were giving feedback about meals and their leisure choices.
• Staff felt things were improving and they were more involved in making decisions recently. One member of staff said, "The new manager is approachable. Some of the changes are better for people; for example, an extra evening member of staff gives flexibility."

Working in partnership with others
• Community partnerships were integral to the 'village' and people had the opportunity to participate in groups and meetings throughout the week.
• There were also relationships with religious groups to ensure people's spiritual needs were met.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People did not always receive safe care and treatment

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The systems in place to manage the home were not always effective in ensuring people received good quality care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were not always sufficient experienced staff deployed to meet people's needs safely and to uphold their dignity.