Richmond Care Villages Holdings Limited

Richmond Village Letcombe Regis

Inspection report

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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

About the service
Richmond Village Letcombe Regis is a retirement village, the care home forms part of the main building. The care home accommodates up to 53 people in two units. The service supports older people and people living with dementia. At the time of our inspection there were 34 people using the service.

People's experience of using this service and what we found
Systems and processes were not always effective in assessing, monitoring, and improving the quality of the service. Concerns found on inspection had not been identified or rectified.

Risks to people had not always been fully assessed or mitigating strategies completed. People were at increased risk of abuse as injuries did not always have a cause or an investigation completed.

There were not always sufficient staff deployed to meet people's needs in a timely manner.

People and relatives had not all been asked to feedback on the service. People and relatives had not always seen or been part of their care plan and staff did not always have time to read people's updated care plans.

People were supported by staff who had been safely recruited and who had received sufficient training.

People were supported safely with their medicines. Staff administered medicines as prescribed and had all the necessary information regarding people's medicines.

Staff felt supported within their roles and felt they worked well as a team.

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 20 February 2021)

Why we inspected
We received concerns in relation to use of equipment, management oversight and falls. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

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

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

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.

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

Enforcement and Recommendations
We have identified breaches in relation to risk management and management oversight at this inspection.

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

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and 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?

Requires Improvement

The service was not always safe.

Details are in our safe 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 Letcombe Regis

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
This inspection was carried out by 1 inspector, 1 Specialist Nurse Advisor 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 Letcombe Regis 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 Village Letcombe Regis 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.

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 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 with 8 people who used the service and spoke to 4 relatives about their experience of the care provided. We contacted 18 members of staff including the registered manager, regional support manager, nurses, and care staff. We observed the interaction between people and staff.

We reviewed a range of records. This included 11 people's care records and medication records. We looked at 3 staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

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; Systems and processes to safeguard people from the risk of abuse

- Not all known risks had been assessed and mitigating strategies recorded. For example, people with epilepsy did not always have the type of seizure they experienced recorded and people with mental health needs did not always have the details regarding how to mitigate the risk of harming themselves.
- Strategies implemented to reduce risks were not always followed. For example, we found records did not evidence people were supported within the specified timeframes with repositioning themselves and records did not evidence people were offered enough fluids. This put people at increased risks of dehydration, skin damage and infection.
- Environmental risks had been assessed. However, we found an open door which allowed other people to access the residential home. People told us that open doors caused them worry. One person said, "Quite a lot of people could get in here easily." Another person told us, "I like to lock the doors, but they (staff) don't."
- People were at risk of potential abuse. When a person had an unexplained injury, the registered manager had not always completed an investigation to identify the potential cause and to put mitigating factors in to reduce the risk of reoccurrence.

The provider had failed to ensure risks to people's health and safety had been assessed and done all that is practical to mitigate those risks. This was a breach of regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The provider had policies and procedures in place regarding safeguarding people. Staff received safeguarding training and understood the signs of abuse and how to report any concerns. Most people we spoke to told us they felt safe. One person said, "It's very nice and they (staff) nurse you if you're not well. I'm very happy here as you can do as much as you want." Another person said, "Absolutely, everything is here for safety, bells to ring. There are always people (staff) about, and I don't ever worry."
- People were protected from risks associated with fire. People had personal emergency evacuation plans in place and the provider completed fire safety checks regularly.
- Equipment used to support people safety was regularly checked to ensure it was working properly.

Staffing and recruitment

- There were not always sufficient staff to meet people's needs. The call bell audit identified on numerous occasions staff were unable to respond to people due to 'all staff attending to another person.' For example, the weekly audit evidenced between 19 May 2023 and 25 May 2023, there were 8 occasions when staff took longer than 10 minutes to respond to people due to not enough staff being on shift.

● The provider used a dependency tool to assess the number of staff needed to meet people's needs. However, the rota evidenced this allocation of staff was not always met. For example, the dependency tool evidenced, and the registered manager told us, 9 staff were required between the hours of 8am and 8pm. The rota evidenced on some shifts there were only 7 staff working. The registered manager told us they 'step in' when required to support, there were also some staff who were supernumerary that could assist when needed.
● We received mixed views on staffing levels from people and staff. People told us there were not enough staff. However, some staff told us they felt sufficient staffing was in place. One person said, "Weekends are not good and this morning it was 10.50am before I was washed and dressed. I wanted a shower but the response I got (from staff) was we are so short staffed we haven't got time to shower people." A staff member told us, "There is not enough staff in the morning especially, when most of the residents would like to be attended to, sometimes at the same times."
● Staff were recruited safely. The provider completed pre-employment checks such as references and Disclosure and Barring Service (DBS) checks. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults, to help employers make safer recruitment decisions.

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's medicine administration records (MAR) evidenced medicines were administrated as prescribed. Information was recorded regarding why a person had been given an 'as required' medicine and staff had the information required to understand when to give medicines and why medicines were prescribed.
● Staff received training in the administration of medicines. People told us they received their medicines as prescribed and at the correct time. One person said, "The day nurse gives them (medicines) in the morning and then the evening nurse does the afternoon. I know what they (medicines) are." Another person said, "They (staff) give me them (medicines) on time. I ask them (what tablets given), I'm somebody who needs to know what's going in my body."
● Medicines were managed safely. This included the storage, administration, recording and disposal of medicines. Regular stock checks were completed

Preventing and controlling infection
● 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 using PPE effectively and safely.
● 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
● The home was open for visitors with no restrictions in accordance with the current guidance.

Learning lessons when things go wrong
● Incidents and accidents were analysed to identify trends and patterns for falls. The information was then communicated to staff so they understood what strategies could be implemented. The registered manager had implemented changes such as additional staff between the hours of 6pm and 12am and was in the process of moving the 'nurses' station' to ensure staff could see people accessing corridors.

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 and processes were not always effective in identifying when a person had an injury that required investigating. The wound care audit did not have all injuries recorded. Therefore, oversight was not always sufficient.
- Systems and processes to ensure records were kept up to date had previously identified issues with fluid records and support offered with repositioning. However, these concerns continued to be found on inspection.
- Systems and processes had not identified the gaps found in the kitchen records. For example, we found cooked food temperatures, fridge and freezer temperatures and kitchen cleaning records had not always been recorded.
- Systems and processes had not been effective in identifying when food had not been recorded. For example, one person who was at risk of malnutrition and had been losing weight, had gaps in the recording of their meals. Therefore, we could not be assured they had been offered a meal at that time.
- Systems and processes had not always been effective in identifying when information was incorrect or missing in care plans and risk assessments. We found 1 person did not have sufficient information recorded regarding their health condition. Another person had incorrect information regarding what strategies staff were required to complete to mitigate their health condition risks. The audit completed only looked at 10% of care plans, therefore, these concerns had not been identified prior to the inspection.
- Staff did not always have time to read people's care plans. Staff told us care plans were not always kept up to date. One staff member said, "Care plans are updated by the nurse and senior carer. Information is collected from the care staff members. However, care plan updating is behind at times. There are days when the nurse works without the senior support, therefore is less time to update the care plans as required." Another staff member said, "Care staff don't have time to read the care plans and seniors/nurses don't have time to always update them."
- People and relatives told us they were not involved in their care planning and most stated they had not seen a copy of the care plan or risk assessment. One person told us, "I haven't seen anything (care plan)." A relative said, "I have never seen [person's] care plan."

The provider failed to ensure adequate systems and processes were in place to assess, monitor and improve the quality and safety of the care provided. This was a breach of regulation 17 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The registered manager implemented changes, mitigated risks, and updated records immediately after the inspection.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● People and relatives told us they had not been asked to feedback on the service. Eight people and 5 relatives stated they had never been asked. However, people and relatives told us they knew who the registered manager was and could raise concerns if needed.

● Staff told us they felt supported within their roles and were offered regular meetings and supervisions to share information. A staff member said, "I can talk to [registered manager] as needed. If I have any concerns, the office door is always open."

● The registered manager told us they were in the process of setting up access to the electronic care plan system for relatives.

● Staff knew how to whistle-blow and knew how to raise concerns with the local authority and the Care Quality Commission (CQC) if they felt they were not being listened to or their concerns were not acted upon.

Continuous learning and improving care; Working in partnership with others

● The registered manager was open and transparent throughout the inspection.

● The registered manager worked in partnership with other health and social care professionals. Referrals were made to the appropriate health care professionals as required.

● Relatives told us the staff kept them up to date on any changes. One relative told us, "[Person] has had some falls and staff notified me as soon as was practical."

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 registered manager understood their responsibility under the duty of candour. The duty of candour requires providers to be open and honest with people when things go wrong with their care, giving people support and truthful information.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to ensure risks to people's health and safety had been assessed and done all that is practical to mitigate those risks.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to ensure adequate systems and processes were in place to assess, monitor and improve the quality and safety of the care provided.