Richmond Villages Operations Limited

Richmond Village Painswick DCA

Inspection report

Stroud Road
Painswick
Stroud
Gloucestershire
GL6 6UL

Tel: 01452813902
Website: www.richmond-villages.com

Date of inspection visit:
01 February 2017

Date of publication:
16 March 2017

Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection was unannounced and was carried out by one adult social care inspector. The previous inspection of the service was in August 2014. At that time there were no breaches of the legal requirements.

Richmond Village Painswick DCA provides care and support services to people living in their own 'purchased' homes, within the Richmond Village retirement complex. People live in the independent living apartments (ILU) or the assisted living suites (ALU). People pay a monthly service charge and this covers the provision of all meals, or food items to prepare meals plus housekeeping services. At the time of the inspection the service were supporting 20 people, (three people in the ILU and 17 in the ALU), The service had 14 care staff and one team leader.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider.

The registered manager and care staff were knowledgeable about safeguarding issues and knew what to do if there were concerns about a person's safety. All staff received safeguarding adults training. Robust recruitment procedures were followed to ensure only suitable staff were employed. Appropriate steps were taken to protect people from harm.

Any risks to people's health and welfare were identified and then managed to either reduce or eliminate the risk. The level of support people needed with their medicines was identified in their care plan. Staff received safe medicines administration training to ensure they were competent to undertake the task. The competency of each staff member was re-checked regularly to ensure they continued to follow best practice.

Care staff had a mandatory training programme to complete which enabled them to carry out their jobs well. They received support from the registered manager and the team leader and were regularly supervised. New staff had an induction training programme to prepare them for their role and then completed the Care Certificate. All care staff had either already completed a qualification in health and social care (formerly called a national vocational qualification), at least at level two, or were working towards the award.

Staff understood the principles of the Mental Capacity Act 2005 (MCA). The MCA provides the legal framework to assess people's capacity to make certain decisions. Whilst the arrangements for receiving a service were being put in place, people signed their agreement to the plan of care. Care staff ensured that people consented before any care or support was provided each time they visited.

People were provided with support with meals and drinks where this care and support need had been identified. People may be supported to go to the restaurant to have their meals or the care staff would

support them with food and drink preparation in their own home. People were supported to see their GP and other healthcare professionals as necessary.

The care staff had good, kind and friendly working relationships with the people they were looking after. Staff ensured people's privacy and dignity was maintained at all times.

The service had good processes in place to assess people's care and support needs and then to plan the delivery of their care. They received the care and support they needed and were looked after in the way they preferred. This was because they were involved in making decisions about how they wanted to be helped. People were encouraged to express their views and opinions and say whether the service was meeting their expectations.

The provider had quality assurance measures in place to monitor the quality and safety of the service. This meant people received the service they expected and it was safe, effective and caring, responsive and well-led. The service used any feedback from people to make improvements and learned from any complaints, accidents or incidents to prevent further occurrences.

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 remains safe	Good
Is the service effective? The service remains effective.	Good
Is the service caring? The service remains caring.	Good
Is the service responsive? The service remains responsive.	Good
Is the service well-led? The service remains well-led.	Good

Richmond Village Painswick DCA

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, and to provide a rating for the service under the Care Act 2014.

This comprehensive inspection took place on 1 February 2016. The inspection was announced. We gave the registered manager 48 hours notice of the inspection because the service is small and we needed key people to be available.

The last inspection of Richmond Village Painswick DCA (domiciliary care agency) was completed in August 2014. At that time there were no breaches in regulations. This inspection was undertaken by one adult social care inspector.

Prior to the inspection we looked at the information we had about the service. This information included any statutory notifications the service had submitted to CQC. A notification is information about important events which the service is required to send us by law. We also reviewed the previous inspection report and contacted two social care professionals as part of the planning process.

We reviewed the Provider Information Record (PIR) that had been submitted. The PIR is information given to us by the provider. This is a form that asks the provider to give some key information about the service, tells us what the service does well and the improvements they planned to make.

We sent domiciliary care agency questionnaires to people who use the service, relatives, staff and community professionals and have used their feedback as evidence and reported this in the main body of the report. We received completed questionnaires from the following - 11 people, four relatives/friends, 10 staff and one community professional.

During the inspection we visited five people who used the service and spoke with three representatives (these may be relatives or friends). We spent time with the registered manager, the 'Village' training officer, the team leader and five care staff.

We looked at four people's assessment and care records, three staff recruitment files and the training records and other records relating to the management of the service. We looked at a range of policies and procedures including, safeguarding, whistleblowing, complaints and the safe management of medicines.

Good

Is the service safe?

Our findings

People who used the service and their representatives thought the service was safe. They said, "I have every confidence in the care staff", "The girls always check that I am alright", "They are all very good to me", "They always make sure I have my pendant with me so I can call for assistance if need be" and "I feel safe and the care staff always call out who they are when they come in to my home".

Those people who returned the questionnaires we had sent them prior to our inspection all said they strongly agreed or agreed they felt safe from abuse or harm from the care staff. Representatives who completed the forms also reported that the person who used the service was safe.

The service had a safeguarding vulnerable adults policy and this was kept under regular review. The registered manager had put together a safeguarding folder for the staff to refer to and kept in the care office. The folder contained a copy of the policy and a copy of the Gloucestershire County Council fact sheet. Care staff we spoke with referred to the folder and knew what to do if they had concerns about a person's welfare, they witnessed bad practice or were told about an event that had happened. All care staff completed safeguarding training and the registered manager and team leader had completed level three safeguarding training with the local authority.

Safe recruitment and selection processes ensured the right staff were employed. Relevant checks were carried out before new care staff started work These checks included a Disclosure and Barring Service (DBS) check. A DBS check allowed employers to check whether an applicant had a police record which would prevent them from working with vulnerable people. Written references were obtained from previous employers.

Prior to the service being provided an assessment of any risks was carried out. This included an assessment of the person's home to ensure it was a safe place for the staff to work. Care staff were expected to report any new risks they identified. There was a process in place to report any accidents or incidents and care staff were expected to follow this. Where people were assisted to move and transfer from one place to another their support plan stated any specific equipment to be used and the number of care staff required to undertake the tasks. All risk assessments were reviewed on at least a six monthly basis.

The service has a 'village wide' emergency/escalation plan in place. This set out emergency contact telephone numbers and the on- call arrangements for senior managers.

The service provided care and support to people who lived within the Richmond Village complex, in the independent living apartments and the assisted living suites. At the time of the inspection the staff team consisted of the registered manager, a team leader and a team of care staff. There were sufficient staff to meet the care and support needs of each person who were being supported by the service. The service had an on-going recruitment process in place.

The service had a handling medicines and drugs policy in place. This was due for review in September 2017.

The policy stated that care staff could help people to re-order their medicines, were trained to administer medicines safely and were not permitted to administer over-the-counter medicines. Spot checks were made of the care staff administering medicines to check they were competent and followed safe practice. Staff we spoke with confirmed that training and competency assessments had been carried out. People were protected against the risks associated with medicines because of the measures in place.

People were assessed to see if they needed help with taking medicines to determine the level of support they required. The level of support needed was agreed upon and the person gave written consent as part of the overall agreement to care. Their support plan stated whether the care staff had to prompt or remind, assist or administer the medicines. Care staff completed a medicine administration record after medicines had been given. Because of the measures in place we found that people were protected against the risks associated with medicines.

Good

Is the service effective?

Our findings

People told us they received the service they expected. They said, "They come each day and make sure I am alright. I am very satisfied with the help given", "I get the service I need. You can set the clock by the staff, their time keeping is good" and "They have their set times to call but if I got in to difficulty I can use my call bell to get help". Two representatives of people who were supported by the service said the service was very effective. One commented, "(named person) is living now instead of just existing". They felt that the person's move to the village had brought about significant improvements in their well-being.

People who returned our questionnaire said they would recommend this service to other people and that the service enabled them to be as independent as possible. People were positive about timekeeping, the skills and knowledge of the care staff and said that all tasks were completed. Three of the four relatives/friends were positive about the effectiveness of the service but one relative did not feel care staff arrived on time, completed all tasks or stayed for the agreed length of time. This however contradicts all other feedback we have received.

The staff talked about the people they supported and were knowledgeable about their care needs, their daily routines and their individual preferences.

All of the staff received the training they needed to do their job effectively. New staff had a six day induction programme to complete. This covered a welcome to the whole village, person centred care, equality and diversity and essential training that all staff had to complete. Post induction new care staff completed the Care Certificate. The Care Certificate was introduced for all health and social care providers on 1 April 2015 and consists of 15 modules to complete. All modules were expected to be completed within the first three months of employment. The registered manager told us all staff, however long they been working in care were going to be completing the certificate.

For all care staff there was a programme of refresher training to be completed. Examples of training included health & safety, food safety, safeguarding/MCA/DoLS, infection control, dementia awareness, medication awareness and moving and handling. The service maintained records which showed training dates and identified those who were due refresher training. The training officer and registered manager kept an overview of the programme to ensure that all staff remained up to date.

Care staff were expected to undertake level two health and social care qualifications after six months working for the service (now called a diploma but previously called a National Vocational Qualification (NVQ)). The whole staff team either already had their level two or three qualification or were working towards the award. The team leader had just completed the level five leadership and management award. The registered manager had achieved the registered managers award plus other relevant business and management qualifications.

Care staff were well supported and had regular one to one supervision with the registered manager and an annual appraisal. Spot checks were undertaken by the team leader and the registered manager to look at

their work performance and check how they interacted with people. Staff starting work had a full handover report from those staff going off duty. Regular staff meetings were scheduled, the last one being 22 November 2016. Staff were actively encouraged to design the agenda for meetings to cover any specific topics/questions they wished to include. Minutes of the meetings were sent to those care staff who could not attend and this was confirmed by those care staff we met.

People's capacity to make decisions and to give consent was assessed as part of process in setting up of a service for them. People were involved in their assessments and asked to sign their agreement to the support plan and service delivery arrangements. Care staff understood the need to gain people's consent before starting to provide care and support. They respected people's rights to be independent and to make their own choices. Mental Capacity Act 2005 (MCA) training was covered as part of the mandatory training programme for all staff. The MCA sets out what must be done to make sure the human rights of people who lacked mental capacity to make decisions were protected.

The service had an MCA policy and a Deprivation of Liberty Safeguards (DoLS) policy. Both were kept under review. DoLS legislation does not apply to this service because care staff were providing care and support to people in their own homes and their liberty was not being restricted.

People were supported to eat and drink where this was identified as a need. The level of support to be provided was detailed in their care plan. People were provided with support to prepare their meals and drinks or supported to eat their meals where necessary. People may be supported or escorted to go over to the restaurant by the care staff for meals. However, their meals can be delivered to their apartments/suites by the hostess staff. Any risks associated with eating and drinking, for example poor dietary intake, dehydration or choking was made clear in the plan with details on how to reduce or eliminate that risk. Care staff were expected to report any concerns they had about people's eating and drinking to the team leader/registered manager and where necessary to the GP. The registered manager told us when people were unwell, they would instigate extra visits to monitor the person's fluid intake. Where needed the care staff would check stocks of food items, check the fridge on a daily basis and collect any food items needed.

People were registered with their own local GP. Care staff may support them to make appointments and arrange for repeat prescriptions as part of their care package. Where health and social care professionals were also involved in the person's community support, the care staff worked alongside them to make sure people were well looked after. Examples included working with community based occupational therapists, physiotherapists, district nurses, dementia specialist nurses and mental health services. One person told us they were waiting for some adaptations to be made to their bathroom and the registered manager was in communication with the occupational therapist to escalate the works.

Good

Is the service caring?

Our findings

People said, "All the staff are very kind to me", "The staff are always polite and respectful to me", "The girls all treat me very nicely" and "I have been so impressed with how helpful the carers are since I have moved in. When there is time they sit and chat with me". People who completed the CQC questionnaires agreed or strongly agreed that they were happy with the care and support provided by the service, were treated with respect and dignity and the care staff were caring and kind. The feedback from relatives and friends and a community healthcare professional was the same. The representatives we spoke with during the inspection were very complimentary about the care team. They said, "The staff have a very good rapport with (named person)", "We have a very enjoyable time with the staff, they cheer us up" and "The girls are brilliant. She can be challenging at times but the staff handle her so well".

The registered manager kept a log of compliments received about the service. These included, "Amazing support", Staff friendly and bright", "Reliability, continuity of care and timing excellent" and "The care staff make me feel happy and comfortable". Feedback from the relatives of one person who had a short stay in one of the suites, including support from the care staff (a try-before-you-buy scheme) was, "Thank you for the care and attention to my mum".

The registered manager and care staff had positive working relationships with the people they supported. We asked the care staff if they would recommend the service to a family member or a friend and we received positive responses each time. Care staff were knowledgeable about people preferences and the things they liked. An About Me document was used to document important information about the person. Each person received a person centred service and care staff treated them as individuals.

People were looked after by a small team of care staff who only worked within the retirement village. The care staff were able to get to know the people well and would know if they were unwell or off-colour. The registered manager explained that staff working schedules were worked on a two weekly rolling rota.

Richmond Village had an 'employee of the month' scheme in place and the registered manager told us that two of the team had received the award. This was because they had 'gone the extra mile'. One of the care staff told us they were the activities champion for the team and they helped arrange 'VIP trips' for people in the apartments/suites who were unable to go on the village trips. This meant people were able to participate in preferred activities and receive the level of support they required from the staff. They told us about previous trips to Bourton-on-the-Water, the seaside, garden centres and to see the bluebell woods. More recently they had taken one person to the supermarket to buy food specifically for them that they liked and would eat (basic food provisions were provided as part of the service charge agreement in place). This person told us they had really enjoyed going out to the shops and choosing their own purchases. The registered person told us about another person who wished to be provided with freshly-squeezed orange juice at breakfast time, but the kitchens provided 'bought' orange juice. The registered manager was advocating upon behalf of the person to get this sorted.

People and their family, friends or representatives were involved in making decisions about their care and

support and had a say in how they were to be looked after. They were asked by what name they preferred to be called, whether this was their first name or a more formal greeting. People were involved in compiling their plan and asked about things that were important to them. They signed their agreement to the plans. For example one person's plan said, "If I am having a tired day, please respect my wishes and leave me to rest".

The service would continue to support people in their own homes when they were unwell or at the end of their life. They would work in conjunction with the family or representatives and healthcare professionals. The registered manager said the staff team would pull out all the stops to look after people in their own homes. One representative we spoke with during the inspection told us their friend was very poorly and their greatest wish was to "stay in their own home".

Good

Is the service responsive?

Our findings

People received the service they needed. They told us, "We had conversations with the manager before we moved in and talked about the help I need", "The care staff help me with everything I need and are very helpful. They will always do little extra's if I ask" and, "I am very satisfied with everything but if I was unhappy I would ask to see the manager. The representatives we spoke with agreed the service provided was responsive to people's needs and was adjusted as often as was necessary.

Those people who returned the CQC questionnaires were asked whether they were involved in making decisions about their care and support needs, whether they knew how to make a complaint and whether the service responded appropriately to their complaints. All respondents said they were involved in decision making, nine of the 11 knew how to make a complaint and felt the service would respond to any complaints or concerns well. All relatives or friends who responded felt complaints or concerns would be responded to and agreed or strongly agreed that the service communicated well with them.

People's care needs were assessed by the registered manager or the team leader. The registered manager told us they liked to be involved in setting up the care arrangements prior to the person purchasing the apartment or suite. This was to ensure the service was able to meet the person's needs and the person's expectations did not exceed what the service was able to offer. A support plan and a timetable of support was written and copies of these were kept both in the office and also in the person's own home. The care staff were provided with clear instructions of the tasks they were expected to complete each time they visited.

Because every person who received a service lived within the retirement village, their care and support needs were kept under continual review. When their needs changed either temporarily due to illness or long term because of a decline in their health the support provided was adjusted. This meant people would be provided with the support they needed to remain in their own homes where this was possible.

As well as formal reviews the team leader completed spot checks and visited people whilst a member of staff was supporting them. During these the team leaders were able to assess the member of staffs work performance, the interaction with the person and assess the person's view on how things were going. These measures ensured people were able to feedback their views about the service they received and make any suggestions and also the quality of service provided was monitored.

People were provided with a copy of the statement of purpose and service users guide and these were placed in the care files in their home. Both documents informed people how to raise any concerns or complaints they had. In the communal areas of the 'retirement village ' and the reception area, leaflets were displayed (How to raise a concern or make a complaint). Those people we spoke with felt they would feel comfortable raising any issues they had. The service had not received any formal complaints in the last 12 months and CQC had received no information of concern. However the registered manager maintained a log of "Grumbles". This was used to identify any low level issues and enable the staff to 'nip things in the bud' at an early stage. The type of grumbles recorded included comments about the quality of meals, the

standard of cleaning and activities. Whilst these were 'retirement village' issues, the registered manager was addressing these with the village manager.

Good

Is the service well-led?

Our findings

People said, "Yes I think the service is very well organised", "Without exception all the staff are very professional, working together as a team" and "I only have to ask to see the manager and she will come along". Representatives were complimentary about the service, said they had never been let down by the service, they were not aware any visits had been missed and the calls were made at the expected time.

People who returned the CQC questionnaires were asked if they knew who to contact in the service, whether they had been asked for their views about the service and, if they had received information from the service that was clear and easy to understand. All respondents agreed or strongly agreed they would know who to speak to in the service and had been given the relevant information. Seven people who responded said they had been asked what they thought about the service provided which meant that four did not think they had. This however conflicts with all other evidence we have been provided with.

The domiciliary care service provided was encompassed as part of the retirement village services. The registered manager was supported by other managers within the retirement village, (the village manager and the head of care) and the registered domiciliary care managers at other retirement village sites. Each week there was a head of departments meeting where 'people in the village', any emerging risks and issues were discussed.

There was a staffing structure in place. Since the last inspection there has been a change and a new manager was appointed in 2015 for the domiciliary care team. The care home, also within the retirement village had their own manager. The team was led by the registered manager, had one team leader and 14 care staff. The team leader organised the staff rotas, ensured all planned calls were filled and worked alongside care staff, completed the spot checks and covered shifts. The registered manager completed the majority of staff supervisions and provided good leadership and management for the staff team. This was confirmed by those staff we spoke with. The registered manager was keen the whole staff team took responsibility for the quality of the service. Six of the care staff were champions within their area of interest. For example, medicine management, administration tasks, infection control and nutrition.

In the evenings and at weekends there was an on-call system for care staff who needed support and advice if they were dealing with a difficult situation. Staff said the arrangements worked well. The on-call cover was provided by the registered manager or the team leader but was generally only used to give advice. Care staff were also able to call upon care home staff who were also on site within the retirement village. There was also a manager on call for the whole of the retirement village.

The service used a variety of different ways to assess the quality and safety of the service. This ensured the service was meeting it's aims and purpose. All policies and procedures were kept under review by the provider and updated where necessary. Quality assurance audits were completed on a three monthly basis. These looked at each of the five CQC questions (is the service safe, effective, caring, responsive and well-led). The last audit had been completed on 3 January 2017. A number of comments and action points resulted from the audit and the registered manager had put together an improvement plan. The plan was shared

with the staff team and will be monitored by the 'village' senior management team. The action plan following the October 2016 audit was shared with us and all actions had either been addressed or the improvements were subject to 'on-going monitoring'.

Feedback was gathered from people and their representatives. The service used reviews, surveys and comments made during 'service user get-together meetings' held in the main lounge area of the village.

Any complaints, accidents or incidents and safeguarding alerts were recorded and reported upon on a monthly basis. However the registered manager always informed the village manager of any such events as they happened. Events were analysed to look for trends and enabled the service to make improvements and prevent reoccurrences.

We received one notification from the service in the last 12 months in respect of a person who had fallen and sustained a bony injury – this injury did not happen whilst a member of care staff was with them. The registered manager was aware when notifications had to be sent in to CQC. These notifications would tell us about any events that had happened in the service. We use this information to monitor the service and to check how any events had been handled.