HC-One Limited

Richmond House

Inspection report

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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

This comprehensive inspection took place on 12 August 2016 and was unannounced. The inspection team consisted of two adult social care inspectors. At the time of the inspection, there were 47 people living at Richmond House.

Richmond House is registered to provide accommodation with care and nursing support for up to 49 people. Ten of the bedrooms are for use by people requiring intermediate care and support for a short period of time. The home is set within its own grounds with car parking facilities.

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. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People we spoke with who lived at Richmond House told us they felt safe. Staff rotas showed that there was sufficient care staff on duty to meet the needs of people who used the service. The service took into account people's needs and their dependency level, using a dependency level tool based on information in people's care files.

There was an up to date safeguarding policy in place, which referenced legislation and local protocols. Staff demonstrated an awareness of safeguarding and were able to describe how they would make a safeguarding referral. The home also had a whistleblowing policy in place.

We looked at six staff personnel files and found there was evidence of robust recruitment procedures, including background checks.

Medicines were managed safely within the home. All staff authorised to administer medicines had completed the necessary training as well as having their competency assessed.

The home was clean and free from any malodours. Bathrooms had been fitted with aids and adaptations, including different coloured hand rails and toilet seats, to assist people with limited mobility and to help people living with a dementia to better orientate in these rooms.

Staff were aware of precautions to take to help prevent the spread of infection. The home was adequately maintained and any equipment used was serviced and maintained appropriately to ensure it was safe to use.

There was an up to date a fire policy and procedure. There was an emergency contingency plan in place which included information of what action to take as a result of an unforeseen event.

There was an accidents/incidents record book which had been appropriately completed.

Staff received appropriate training and supervision/appraisal in line with the frequency identified in the supervision policy.

Staff were subject to a formal induction process and probationary period and had completed training in a variety of areas relative to their job role.

The service was working within the principles of the MCA and any conditions on authorisations to deprive a person of their liberty were being met. Staff were aware of how to seek consent from people before providing care or support. Relatives told us that communication with them was good.

The mealtime experience for people living at Richmond House was positive. We saw that when serving meals staff made reference to a meal list which identified what each person had chosen and who was on a specialist diet.

There were some adaptions to the environment, which included pictorial signs on the doors and contrasting coloured grab rails in the toilets/bathrooms which would assist people living with a dementia. People's bedrooms were personalised with items of furniture and personal belongings such as ornaments and pictures. Peoples' bedrooms had their picture on the door, which would assist people living with a dementia to find their own room.

People who used the service and their relatives told us that staff respected their privacy, promoted their independence, were kind and caring and respected their choices. Staff were aware of how to ensure people's privacy and dignity was respected. We observed people were treated with kindness and dignity during the inspection and care staff spoke with people in a respectful manner.

People living at the home were well groomed and nicely presented. We observed staff encouraging people to become involved in activities.

Residents and relatives meetings were held monthly and the notes of previous meetings were posted on the wall for anyone to access.

Each care file had a section about advanced decisions. Where people had made an advanced decision regarding end of life care this was recorded correctly, dated and signed appropriately. The service followed the 'North West End of Life Care Model' which was advocated by 'NHS North West clinical pathway group.'

We saw evidence within each care file that people and their relatives were involved in care planning. We saw evidence of person centred practice within the care files we viewed which held information that would allow staff to understand people's individual choices and preferences.

Care plans contained a 'remembering together' document which included information about the person's

family, friends, work history and interests.

The home had pressure ulcer notification forms in place, which were used to document any issues with pressure ulcers. Each person had a risk assessment, care plan and the appropriate pressure relieving equipment in place.

Satisfaction surveys were sent to people who used or previously used the service. The home included people who lived at Richmond House in the interview process for new care staff, sitting-in throughout the process and drawing up and asking their own questions.

There were activities and entertainment rooms in which people could pursue hobbies, relax or socialise with friends and family.

All the relatives we spoke with confirmed they knew who to speak to if they had any concerns or wished to complain. Copies of the complaints procedure were clearly displayed throughout the home.

The staff we spoke with said there were regular team meetings where they discussed their work and received feedback on their performance.

We saw that the home had a comprehensive range of policies and procedures in place and hard copies were available in a file. There were systems in place to regularly assess and monitor the quality of the service. The home completed regular audits in a number of areas including care plans, medicines management and environmental safety.

The home had a 'resident guide' in place. This provided people with all the information they needed about the service including the philosophy of care, registration information, who the manager was and their background, how the home was run, what was available and how to make a complaint.

The manager operated an 'open door' policy and a notice was posted on their office door identifying that anyone could speak to the manager at any time or arrange a meeting if preferred.

We saw that the manager or deputy manager completed daily walk rounds of the home in order to observe and monitor specific areas of the service. Night visit checks were completed by the home manager on a regular basis.

The service appropriately submitted statutory notifications to CQC as required and had notified CQC of all significant events, which had occurred in line with their legal responsibilities.

The service worked in partnership with the local authority contracts monitoring team. A range of information was also sent each month to the health and social care information centre (HSCIC) in the form of the NHS Safety Thermometer.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe. Staffing levels were sufficient on the day of the inspection to meet the needs of the people who used the service and there was evidence of robust recruitment procedures.

People we spoke with who lived at Richmond House told us they felt safe.

Records of medicines administration had been completed consistently and accurately. Accidents and incidents were recorded correctly.

Is the service effective?

Good

The service was effective. Staff were subject to a formal induction process and probationary period and there was a staff supervision schedule in place.

The service was complying with the conditions applied to DoLS authorisations.

Staff were aware of how to seek consent from people before providing care or support. People's care plans contained records of visits by other health professionals.

There were some adaptions to the environment to assist people living with a dementia.

Is the service caring?

Good

The service was caring. Staff spoken with had a good understanding of how to ensure dignity and respect and staff showed patience and encouragement when supporting people.

We heard lots of laughter between staff and people and there was a positive atmosphere within the home.

The service involved families when developing care plans or carrying out assessments.

Is the service responsive?

Good

The service was responsive. Care files were well organised and contained care plans that covered a range of health and social care support needs.

Each person had a detailed care pathway, an assessment of possible risks and a description of the person's needs for support and treatment.

The home had procedures in place to receive and respond to complaints.

Is the service well-led?

Good

The service was well-led. There was a registered manager in post.

People we spoke with and their relatives told us they thought the service was well-led.

There were a variety of systems in place which helped the service to monitor the quality of care provided and the service undertook a range of audits.

Richmond House

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, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This comprehensive inspection took place on 12 August 2016 and was unannounced. The inspection team consisted of two adult social care inspectors. At the time of the inspection, there were 47 people living at Richmond House.

Prior to the inspection we reviewed information we held about the home in the form of notifications received from the service such as accidents and incidents and reviewed information we received from HM Coroner regarding the safe management of medicines. We also contacted Wigan local authority quality assurance team, who monitors the service.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We spoke with six people who used the service, five relatives and ten members of staff including care staff, the registered manager, the deputy manager and the area manager. We also looked at records held by the service, including six care files and six staff personnel files.

As part of this inspection we 'case tracked' care records for people who used the service. This is a method we use to establish if people are receiving the care and support they need and that risks to people's health and wellbeing were being appropriately managed by the service.

We observed care within the home throughout the day including the lunchtime medicines round and the

morning and lunchtime meal.

Good

Our findings

People we spoke with who lived at Richmond House told us they felt safe. Comments received from people who used the service included, "Yes, I feel safe here," and "I have never had any cause for concern," and "If I didn't feel safe I would certainly move elsewhere." Comments received from people's relatives included, "I have no concerns about the quality of care," and "I always get told about any changes to [my relative's] care and support," and "Staff are always available and willing to help in any way," and "[My relative] stayed for intermediate care and was looked after to the highest standards. Nothing was too much trouble for any of the staff."

We looked at the staff rotas for August 2016 and these demonstrated that there was sufficient care staff on duty to meet the needs of people who used the service. There was one nurse and two care staff for the ten intermediate care beds, and two nurses and six care staff for the remaining beds. These were supported by the manager, domestic, kitchen and administrative staff.

We received mixed comments about staffing levels from people who used the service. One person said, "The staff are very good but have been a bit short recently, though when I call for help they come straight away." Another person told us, "They are very busy, but I've not had to wait a long time for anything; a carer comes as soon as they can." A relative said, "Staff are always available and willing to help in any way." Another relative commented, "Staff are very friendly and there seems to be enough of them around."

When determining the level of staff required to meet people's needs, the service took into account people's needs and their dependency level, using a dependency level tool based on information in people's care files. From this information the home was able to identify safe staffing numbers relative to individual people's needs. Additional staff were rostered in to escort people for example to hospital appointments and to ensure adequate staff cover within the home. A staff member told us, "We could always do with more time to spend with people, but have a lot to do during a shift. No one misses out though and all needs are met." Another staff member said, "The home is run well, we don't struggle with staffing, we've got a good team who all work together."

We looked at six staff personnel files and found there was evidence of robust recruitment procedures. The files included application forms, records of interviews, proof of identity and references. There were Disclosure and Barring Service (DBS) checks undertaken for staff in the files we looked at. A DBS check helps a service to ensure the applicant's suitability to work with vulnerable people.

There was an up to date safeguarding policy in place, which referenced legislation and local protocols. We spoke with four care staff who demonstrated an awareness of safeguarding and were able to describe how they would make a safeguarding referral. Staff were aware of potential signs of abuse or neglect and of how to report any safeguarding concerns appropriately. Staff told us they had contact numbers for the local authority safeguarding team should they need it, which we observed during the inspection. Comments received from staff included, "I would contact the central duty team at Wigan; if unsure I would speak to the manager or deputy," and "I would go to the manager, deputy or a nurse," and "We do safeguarding training and someone from Wigan council also came in and did this training with us."

The home had a whistleblowing policy in place. We looked at the whistleblowing policy and this told staff what action to take if they had any concerns and this included contact details for reporting any concerns. Staff we spoke with had a good understanding of the actions to take if they had any concerns.

We looked at medicines management within the home. Prior to our inspection we received information of concern from HM Coroner regarding the safe management of medicines, where the provider had been requested to review their policies and procedures governing medication management at the home. During our inspection we found that policies and procedure had been reviewed and a number of additional actions had also been taken to ensure the safe management of medicines including; a check on the quantity of medicines brought into the home on arrival; the introduction of a process to follow to identify if there was a discrepancy between medicines prescribed and medicines received into the home; additional support and supervision for staff members involved.

We observed that each person had a medicine administration record (MAR) in place, which included their date of birth, date of admission, room number, GP details, any allergies, any potential difficulties in taking their medicines and choice of how and where they would like to take them.

We viewed eight MAR charts during the inspection. We saw that all prescribed medication had been administered and signed off correctly. We saw that the home had a separate topical medicines application record, onto which medicines such as creams were recorded. We saw that these had been completed consistently. We saw that a specimen signature chart was in place and this corresponded with the staff signatures on the MAR charts.

We completed stock checks of eight people's medicines including three people who took a controlled drug. All medicines we checked had the correct amount remaining, and corresponded with information on the MAR charts, indicating that all medicines had been administered correctly.

We saw that the home used 'as required' medicines (PRN) protocols in place. These explained what the medicine was, the required dose and how often this was required, the time needed between doses, when the medicine was needed, what it was needed for, if the person was able to tell staff they needed it and if not what signs staff needed to look for along with any potential side effects. This ensured that any 'as required' medicines were being administered safely and appropriately.

We checked the controlled drug (CD) cupboard. We saw that this was kept locked with the key stored separately. We checked the stock levels of three medicines in the CD cupboard and saw that these corresponded with the CD register. We noted that all entries were supported by two staff signatures as required. We saw that where people were being given their medicines covertly, which is medicines given in food or drink, the home had sought authorisation from the GP and ensured a care plan was in place.

We saw that all staff authorised to administer medicines had completed the necessary training as well as

having their competency assessed. We noted that the assessment covered staff knowledge, practice competency as well as calculations competency for nurses, to assess their ability to calculate dosages. A staff member told us, "We have to do training and we also complete training provided by Boots pharmacy. There are competency checks which have to be done before we can administer." One person who used the service told us, "I get help with medicines; they bring them at the right time." A relative said, "No concerns with this, they give them on time." Another relative commented, "No concerns at all. They are on the ball with this. I reported an infection last Friday and within three quarters of an hour the GP was here; within an hour [my relative] had new medication."

During the inspection we looked around the premises. We saw the home was clean and free from any malodours. We saw that bathrooms had been fitted with aids and adaptations, including different coloured hand rails and toilet seats, to assist people with limited mobility and to help people living with a dementia to better orientate in these rooms. We saw that liquid soap and paper towels were available in all bathrooms and toilets. The bathrooms were well kept and surfaces were clean and clutter free. There were signs displayed that advised staff how to wash their hands effectively.

Staff were aware of precautions to take to help prevent the spread of infection. For example, staff said they would wash their hands regularly and use different coloured cleaning cloths for different areas of the home. There was infection control guidance for staff in place with information on how to minimise the potential for an infectious outbreak and the action to be taken in the event of an outbreak. An infection control baseline audit had been completed on 14 December 2015 by Public Health and comments received were very positive.

The home was adequately maintained and we saw evidence recorded for the servicing and maintenance of equipment used within the home to ensure it was safe to use. Cleaning products were stored safely and Control of Substances Hazardous to Health (COSHH) forms were in place for all the cleaning products in use. Radiators had appropriate guards to protect against the potential for burns. Daily and weekly cleaning schedules were being followed and were all up to date. There was a 'housekeeping cleaning specification' guide for domestic staff which identified different tasks required, the type of product to use and how to use it, any hazards and what protective equipment to use such as gloves and aprons.

There was an up to date fire policy and procedure. Fire safety and fire risk assessments were in place. People had an individual risk assessment and a personal emergency evacuation plan (PEEP) regarding their mobility support needs in the event of the need to evacuate the building, which was easily available for staff to access. Staff we spoke with were aware of procedures to follow in the event of an emergency, such as an emergency evacuation of the home.

There was an emergency contingency plan in place which included information of what action to take as a result of an unforeseen event such as loss of utilities supply, loss of staffing, fire and flood. The plan included contact numbers for relevant persons and suppliers/contractors.

We saw people had risk assessments in their care plans in relation to areas including falls, pressure sores, and malnutrition. There was a falls team in place at Richmond House who met on a monthly basis to discuss trends and how to reduce the number of falls. There was an accidents/incidents record book which had been appropriately completed and identified the detail of any incident including the name of the person involved, the date and location of any incidents, the cause and the detail of any immediate and subsequent action that was required to minimise any further risk. Where applicable RIDDOR notifications and CQC statutory notifications had been completed. RIDDOR is the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995.

Good

Our findings

A person who used the service told us, "The food is very good and there's enough choice." A second person said, "I get to choose what I want to eat, staff are brilliant with this." A third person said, "Staff know what they are doing." Comments received from relatives included, "The food is great here, always fresh and there's a good choice every day" and "Oh yeah, they know what they are doing; never had a problem." A staff member said, "We have a shift handover sheet and also have a nurse's diary where we can leave information for the team."

We looked at staff training, staff supervision and appraisal information. The supervision schedule identified meetings that had been held or that were planned for the future and these were in accordance with the frequency identified in the staff supervision and performance appraisal policy/procedure. Annual appraisals had either taken place or where scheduled for after the date of the inspection. Supervision sessions for care staff were conducted by the manager who told us they received support from the area manager. We verified this by looking at the notes of staff supervision meetings. Staff told us they received supervision on a regular basis, which they found useful.

Staff were subject to a formal induction process and probationary period. We looked at staff personnel files and saw that there were records which referenced the successful completion of the probationary period. This included records of training undertaken during induction such as safeguarding, infection prevention and control, equality and diversity, person-centred care, dignity, first aid and moving and handling. Training provided was aligned with the requirements of the Care Certificate.

Staff had completed training in a variety of other areas relative to their job role, such as food safety in care (91%); dementia care introduction and person-centred approaches (95%); risk assessment (100%); emergency procedures (91%) and medicines (96%). Staff told us they had received training in these areas. The staff we spoke with were able to tell us about different forms of dementia and said they would meet the support needs of people living with dementia by providing prompting and reassurance. One staff member said, "I have had training in all areas, including dementia and end of life care." Another staff member commented, "Lots of training is provided; seems all we ever do is more training." A third staff member told us, "We have in-house moving and handling facilitators, so it's easy to keep up to date with this."

Two nursing staff had completed a 'Future Leader's' programme and two nursing staff had enrolled on a 'Mentorship' programme. Three senior care staff had completed a 'Care Assistant Development' programme and had achieved competency as nursing assistants.

Richmond House had four RoSPA trained 'safer people handling' coaches who were available to reassess people's changing needs and offer guidance and advice to staff on moving and handling. RoSPA is The Royal Society for the Prevention of Accidents. Two staff had completed a one day training course titled 'moving more often' which outlined the basic concepts of physical activity including; physical activity benefits; barriers and motivators to activity, planning a physical activity programme; risk assessment and safety issues. One staff member attended meetings with the tissue viability service and was the link person for tissue viability within the home.Ten staff had completed training and achieved competencies in relation to venepuncture and were able to effectively obtain blood samples as needed.

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. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

The registered manager showed us records that demonstrated they had followed-up the status of the outstanding DoLS applications at regular intervals. 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 were being met. We found that the service was complying with the conditions applied to the authorisations. Where applications had not yet been authorised, people's care plans contained restrictive practice screening tools, which ensured that the least restrictive practice was being followed. Comprehensive information was kept regarding the status of any DoLS applications, the date applied for and the reason, the date granted, dates that CQC notifications were sent, the dates of expiry/renewal and if a DoLS care plan was in place.

Comments received from staff included, "DoLS is used when someone's not got capacity; we need to ensure the least restrictive is used," and "I have had training in MCA and DoLS," and "Myself and the deputy went on a training day organised by the local DoLS team," and "DoLS stands for deprivation of liberty; I have had training in this and understand it." Staff training records identified that 93% of all staff had completed training in understanding MCA/DoLS. We saw people had mental capacity assessments in their care plans, which were up to date. Staff were made aware of any DoLS, their expiry date and any conditions attached to the authorisation which meant that the rights of people who used the service were promoted and respected.

DoLS records were cross referenced with people's care plans, whiteboards, DoLS logs and authorisations, to ensure staff were aware of any conditions and expiry dates. This ensured that the rights of people using the service were promoted and respected. Capacity assessments indicated when capacity was assessed, how mental capacity was maximised and where people lack capacity for a specific decision, how that decision was made and recorded in compliance with the Mental Capacity Act.

Staff were aware of how to seek consent from people before providing care or support. Staff told us they would always ask before providing care and would ensure any practice was the least restrictive option. One staff member said, "For people with capacity I would ask if it's okay before I do anything. For people without capacity, I would explain what I am doing and if they become agitated then I assume they are not consenting." Staff told us if people refused care, such as assistance with bathing, they had the right to do so. One staff member said, "If people can respond verbally I would ask them first, if not I would find other ways. I

would also get families involved and ask them." Written consent was also obtained and documented in people's care files, for example for the use of a photograph or to share care plan information with other relevant professionals.

Relatives told us that communication with them was good. One relative said, "They are really very good at communication; [my relative] was poorly recently and they kept in regular contact with me about her health." A second relative told us, "We always get told if there are any changes to [my relative's] care and support." On each day of the month one person was identified as 'resident of the day' and on this day they had a review of their care with family and key members of the care team.

We looked at the mealtime experience for people living at Richmond House. We saw that the home had a four weekly menu cycle in place, which was nutritionally balanced. We noted that for lunch people had the choice of creamy carrot soup and sandwiches, or beef burgers with relish, and fruit pavlova meringue. There were two choices for evening meal along with a different dessert. Each day the menu also advertised a 'cake of the day' which was available with any meal. The menu was displayed in the dining room which was pleasantly decorated and tables were laid with table cloths, cutlery and condiments. The kitchen held records of anyone who was on a special diet, such as a soft or pureed, and any allergies or food intolerances.

We saw that when serving meals staff made reference to a meal service checklist. This stated what each person had chosen, who was diabetic and who was on a fortified, soft, mashed or pureed diet. Each person was offered and served a chilled drink and a choice of meal at the point of service. During the course of the inspection we observed a staff member talking to a relative about food options. The relative asked if it was okay to bring in some pureed fruit, as this was something the person liked to eat. The staff member stated that they would have to check with the speech and language therapy team (SALT) if this would be okay and would let them know. A protected mealtime policy was in place at Richmond House but relatives could sit with people during a meal if this was the choice of the person and their relative.

Each person who used the service had a keyworker and named nurse who liaised with people and their relatives to share information and resolve any issues they may have. The Key Worker provided a crucial link between the person using the service and the overall team working in the home which ensured all personal, social, religious and cultural needs were provided for. The Key Worker took a special interest in their allocated person and were a key point of contact providing assistance with any issues they may have in addition to getting to know their relatives.

We saw there were some adaptions to the environment, which included pictorial signs on the doors and contrasting coloured grab rails in the toilets/bathrooms which would assist people living with a dementia. There were a choice of lounges in which people looked comfortable and relaxed and which included a variety of different seating types. We saw people engaged in conversations or engaged in activities such as reading and completing word puzzles.

People told us they always found the home to be clean and well kept. There were assisted bathrooms with equipment to aid people with mobility problems such as a 'rise and fall' bath. There was a walk-in shower room that was beneficial for people who did not wish to use the bath or who had limited mobility.

There was a secure courtyard garden with access to a potting shed for people who enjoyed helping with the raised flower beds and vegetable garden. A project was underway to develop the garden areas. People who used the service were involved in the planning and design of the garden areas and their involvement and feedback had been gained and was displayed on the dining room window on the ground floor with ideas for the project. Day trips had also been arranged to visit local garden centres and country gardens for

inspiration. Involvement was evidenced on 'thought bubbles' with people's ideas documented, dated and signed by the person.

One person's bedroom, which was at ground floor level, had been fitted with patio doors to enable them to access the garden area more easily, as they regularly went outside for recreational purposes.. The manager told us that they were putting forward a proposal to the provider for all bedrooms on the ground floor to be fitted with patio doors. In one part of the home there was an area that had been designed to look like a public house, with a bar area, tables and seating. People told us they enjoyed using this area to socialise or meet with family/friends.

People's bedrooms were personalised with items of furniture and personal belongings such as ornaments and pictures. Most bedrooms had en-suite facilities and all had TV aerial points and a nurse call system in place.

Good

Our findings

People who used the service and their relatives told us that staff respected their privacy, promoted their independence, were kind and caring and respected their choices. Comments included, "Staff are very caring," and " I am treated with respect very much so," and "The staff knock on my door and privacy is good," and "Yes they are very kind and caring," and "I think they do really well, it's a difficult job; you can talk to any of them, they are all nice," and " [My relative] is more independent here than when at home and goes out with a friend to the local shops."

Staff were aware of how to ensure people's privacy and dignity was respected, for example by knocking on people's doors before entering and ensuring people were covered when providing personal care. A staff member said, "I always knock on the door, shut the curtains and let people choose their own clothes; I ask people for permission before doing anything." A second staff member told us, "I close the door when giving any personal care; I always talk to people and explain what I am doing and make sure they are okay with it."

We observed people were treated with kindness and dignity during the inspection and care staff spoke with people in a respectful manner. We saw that staff knocked on people's bedroom doors and waited for a response before entering. We saw two members of staff entering different people's rooms after knocking and being invited in. One care staff said, "Good morning, can we come in, are you ready to get up yet?" The other care staff said, "Good morning, how are you today? Do you want to get up now?"

We saw that people living at the home were well groomed and nicely presented. Throughout the course of the inspection we heard lots of laughter between staff and people who used the service and there was a positive atmosphere within the home. Staff interacted with people throughout the day and it was clear that they had a good understanding of the individual people who used the service.

We observed many occasions where staff spoke privately on a one-to-one basis with people. For example one staff member was assisting a person to take their medicines. They ensured that they placed themselves at eye level with the person and said, "Are you ready for this my dear?" After taking the medicine, the staff member said, "Well done " in a reassuring manner.

Over the course of the inspection we spent time observing the care provided in all areas of the home. We saw staff warmly greeting people and using appropriate physical contact, such as hand holding. We observed staff encouraging people to become involved in activities and take part in the summer fair, which was being held in the garden on the day of the inspection, whilst respecting the wishes of people who

indicated they would rather remain inside.

On one occasion we observed a staff member asking a person to move back in their wheelchair to enable them to put their feet on the foot plates. The staff member clearly explained what they wanted the person to do and the reasons why, before asking for their consent and before moving each leg onto the foot plates. Due to the person being hard of hearing, the staff member had to explain themselves three times, but remained polite and respectful throughout.

During meal times, we observed positive staff interactions with people, whilst they served food. Staff were polite and respectful at all times, ensuring people were happy, comfortable and had everything they needed. We saw that people were regularly offered drinks, both at meal times and throughout the whole day, and were able to choose between three cold drink options as well as tea or coffee. After giving a drink to one person, the staff member said, "Are you okay, do you want a tissue?" Another staff member told us, "I always give people a choice about the food they would like, what they want to wear, and things like that." Another staff member said, "I always ask what people want first, and also detail people's choices and wishes in their care plan."

Staff told us relatives were able to visit at any time of the day, although they were discouraged from visiting over meal times. We were told however, that it was possible for families to share meals with their relative if they wished.

People's bedrooms had their picture on the door, which would assist people living with a dementia to find their own room. People's spiritual needs were accommodated through the regular home attendance of different faith groups. People's communication and support needs were well documented in their care plans and these sections contained a good level of detail.

Residents and relatives meetings were held monthly and the notes of previous meetings were posted on the wall for anyone to access. A copy of the 'statement of purpose' and 'resident guide' was available and posted in the hallways and people confirmed they had been given a copy of the resident guide (which contained a précis of the longer statement of purpose document) when they first entered the home or when they visited with a view to obtaining a placement. The resident guide contained information on advocacy services, including organisational contact numbers and contact details for CQC and the Local Government Ombudsman if they had any cause for complaint and wished to contact these organisations.

The home operated a 'kindness in care' award which acknowledged and celebrated individual and team efforts within the home. This contributed to building a culture of delivering kind care. People who used the service and their relatives were involved in making nominations for these awards. The Kindness in Care Award recognised the whole community of colleagues at Richmond House including those directly involved with the provision of care to people using the service and their families and those staff members in supporting roles such as housekeeping, catering and maintenance.

Each care file had a section about advanced decisions. Where people had made an advanced decision regarding end of life care this was recorded correctly, dated and signed appropriately. We saw that people had been involved in discussion around advanced care planning, which was recorded within documentation contained in people's care plans. We saw that one relative had found these discussions difficult, not wanting to accept that their family member was at this stage of life. The home requested for the hospice to speak to the relative and provide support. This was done and the relative said they found this beneficial. At the time of the inspection no person was in receipt of end of life care (EOL).

The service followed the 'North West End of Life Care Model' which was advocated by 'NHS North West clinical pathway group'. This model required staff to understand the needs and experiences of people and their carers. In order to ensure staff received the appropriate training in this area, the home was involved in piloting 'Hospice in your Care Home' training with Wigan and Leigh Hospice which staff told us was very useful and rewarding. This included a 12 week programme of training covering areas such as 'definitions of palliative and EOL care,' 'dignity,' 'communication skills,' 'advanced care planning,' spirituality,' and 'recognising dying.' Additionally 100% of staff had completed training in 'venepuncture (phlebotomy)' and 94% had completed training in 'specialist administration of medicines.'

Good

Our findings

During the inspection we looked for evidence of person centred practice. We spoke to people living at the home and their relatives and asked if they had been involved in planning their care. We saw evidence within each care file that people and their relatives were involved in care planning. Either the person or the next of kin had signed to confirm they had been involved in both the initial set up and on-going monthly reviews. One person said, "Its great here, staff are always happy and talk to me about my care needs." One relative told us "They discuss everything to do with [my relative] with us. [My relative] has capacity, so they are involved in these discussions." Another relative said, "Yes, I attended a meeting either at the end of June or beginning of July to discuss [my relative's] care." Another relative told us, "Oh yes I've been involved in discussions about [my relative's] needs all along."

We asked staff about their understanding of person centred practice. One staff member told us, "This is about delivering care that is specific to the person; you need to treat people as individuals." We saw evidence of person centred practice within the care files we viewed and held information that would allow staff to understand people's individual choices and preferences. We saw that one person had a previous diagnosis of mental illness; as well as a specific care plan being in place, the home had also included information leaflets for staff to read, which explained all about this type of illness to ensure they had an understanding of how best to support the person, should any symptoms re-appear.

We saw that another person's first language was not English and as a result they sometimes had difficulties communicating. We saw that a specific communication care plan had been introduced to provide staff with guidance on how best to communicate with this person. We also saw that following some difficulty with the person letting staff know what foods they liked and disliked, the home had met with the person's family to draw up a list of this information which had been circulated to all staff and the chef.

We saw that the home included people who lived at Richmond House in the interview process for new care staff, sitting-in throughout the process and drawing up and asking their own questions. We found that one person who had a background in recruitment was regularly approached to see if they wished to participate.

We looked at whether the home was responsive to people's needs. All the care plans looked at contained a 'remembering together' document which included information about the person's family, friends, work history and interests. Each care plan also had a 'resident profile' in place, this provided information about the person's preferences, things they must have, important things about their lives, their likes, how they told people what help they required and their personal care needs; these two documents helped formulate the

persons care delivery.

We asked staff whether people's needs were reviewed, to ensure care plans remained relevant and effective. One staff member told us, "Needs are reviewed monthly, but if an issue such as swallowing or with their weight crops up, we will talk to the person and their family much sooner." Another staff member said, "Care plans are reviewed monthly, nurses, seniors and the family are all involved in this."

We saw that the care plans also provided guidance around nutrition, communication, continence, mobility, skin integrity, falls, personal hygiene, medication, activities and social care. All of the care plans contained a section containing the person's preferences and support needs. Each person had risk assessments in place which were reviewed when required or monthly. This ensured the service remained responsive to any changing need and effective in minimising risk.

Through looking at care plans we saw that people had access to medical services as needed. Any involvement by the GP, dentist, advanced nurse practitioner (ANP) or other professionals, who visited the home, were detailed in the care plan along with any feedback and relevant information.

Daily meetings were held by senior staff members in order for issues to be discussed and actions allocated to specific staff members. Key clinical indicator information was collected each month such as falls, pressure ulcers, bed rails, infections, hospital admissions and people's weights. Information on how to reduce the volume of these was passed onto staff during scheduled staff meetings or daily meetings.

We saw that each day a different person was selected as 'resident of the day'. Whoever was selected had a full review of their care completed, had their room fully cleaned including carpets and furnishings, and met with the activity organiser and chef to discuss what they would like to do and eat. They also met with the handyman, who ensured that any jobs or tasks the person identified as needing completing were carried out.

The home had pressure ulcer notification forms in place, which were used to document any issues with pressure ulcers. We saw that a person was observed to have a grade two pressure ulcer upon admission. We found that a risk assessment, turning chart, pressure relieving equipment and a care plan was introduced immediately and remained in place.

We looked at three other people who had documented pressure sores. We saw that each person had a risk assessment, care plan and the appropriate pressure relieving equipment in place. A relative told us, "[My relative] hasn't had any pressure sores since he came here; he did have them when he was at home, all the time."

We saw evidence that satisfaction surveys were sent to people who used or previously used the service. An analysis of responses received in the previous two years identified an overall score of 9.7 from a maximum possible score of 10 in relation to the number of positive comments received. We also saw that resident and relative meetings were held every month. We looked at the minutes from the last four meetings and saw that agenda items covered a variety of areas including advanced care planning, with support from the hospice offered, if people would find it easier to talk to them.

Richmond House provided 10 Intermediate Care beds which supported people to regain their independence following a stay in hospital, supported timely discharge from hospital, and enabled people to make an informed choice about their future care needs. An intermediate care brochure had been devised which was given to people prior to their admission from hospital. The brochure was also used as a reference for

hospital staff.

Any prospective new referrals were encouraged to visit the home prior to admission and were encouraged to have a meal in order to appreciate the meal time experience. A pre-assessment was carried out by two staff members to ensure the home was fully able to meet people's needs.

We asked people who used the service for their views on activities. One person told us, "I play dominoes a lot, which I enjoy." Another person said, "I go out a lot with staff help." We asked staff for their opinions on the activity programme in the home. One staff member told us, "Really good, always something going on; two people have gone to Southport for the day today. We've had animals brought in, do bingo, art & craft sessions, gardening, all sorts of stuff." Another staff member said, "The activity organiser takes people on outings of their choice, we have a table in each lounge with games, cards, dominoes, art and craft things on them."

We saw that the home took photographs of people taking part in activities which were dated and displayed on the notice board on each floor. Consent had been obtained from people for the use of photographs. These showed people attending outings to the local café, gardening, completing art and craft projects and playing bingo. The activities coordinator had attended workshops on dementia at a local library along with some people who were living with a dementia. Spiritual needs were catered for through regular visits from different faith groups.

There were activities and entertainment rooms in which people could pursue hobbies, relax or socialise with friends and family. At the time of the inspection a new garden refurbishment project was underway. People who lived at Richmond House, their families and all staff members had been encouraged to contribute ideas regarding the refurbishment work and all ideas were collated and pinned up on a wall so that they could be considered and a decision made regarding what work would be completed. Ideas included new trees, a water feature and a sensory garden.

On the day of the inspection the home was holding a summer fair and this had replaced any other planned activities for that day. We saw that people who used the service had been encouraged to participate with some assisting on the stalls. People were asked if they wished to attend, with those that chose not to, having their wishes respected and remaining in their rooms or in one of the lounges on their floor where they carried out activities of their choice. We saw that many people had chosen to watch television. Richmond House had its own minibus which was available for people to access the local community or for example the local GP surgery, assisted by staff.

Richmond House also participated in four quality assurance themed events which took place at different times throughout the year, the latest one being in June 2016 titled 'Right Royal Blooming Great Tea Party.'

We asked people who used the service if they knew how to make a complaint. One person told us, "I would speak to a member of staff, maybe a superior." Another person said, " I have the information on how to make a complaint but staff are always happy to help so I have no concerns."

All the relatives we spoke with confirmed they knew who to speak to if they had any concerns or wished to complain. We saw that copies of the complaints procedure were clearly displayed throughout the home. The home had a complaints file in place. All complaints had been dealt with appropriately with written responses provided. We saw that one relative had complained about a number of areas of the care being provided. This had been investigated by a quality performance officer (QPO) from Wigan council. The QPO had visited the home and conducted a full investigation into each area of the complaint. No evidence was

found to substantiate the complaints made, with the home being complimented on the care being provided.

Good

Our findings

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. Like the registered provider, they are Registered Persons. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We observed that the manager as visible within the home and supported the staff group and provided advice and support throughout the day of the inspection. People we spoke with and all the visiting relatives we spoke with knew who the manager was. One relative told us, "She's very approachable, I am happy with everything at the home."

The staff we spoke with told us the home was well led and managed and they enjoyed working there. One staff member said, "I enjoy working here, I like the development opportunities." Another staff member told us, "It's a very nice place to work." A third staff member said, "They listen to you when you have suggestions and will take these on board, they're very good with this." A fourth staff member commented, "The manager is really good, very approachable, I class her as a friend." Another staff member said, "Both the manager and deputy are approachable, they are both very good."

The staff we spoke with said there were regular team meetings where they discussed their work and received feedback on their performance. One staff member told us, "In team meetings we get positive feedback about our performance and we get given awards." We saw evidence that meetings took place in the form of minutes. We observed that the meetings covered daily practice, areas for improvement and were also a forum to provide information. We saw that the home had a meeting attendance sheet in place along with a log, in order to keep track of staff's attendance over the course of the year.

We saw that on one occasion staff had been made aware of the findings from a coroner's case that was entirely unrelated to the home. The coroner had identified a link between smoking and use of E45 cream, which was judged to have been a substance that speeds up a chemical reaction, and therefore a potential fire risk, if used near to a flame. This information had helped to inform practice within the home so that this cream was used safely, where relevant.

We saw that the home had a comprehensive range of policies and procedures in place and hard copies were available in a file. These included key policies on medicines, safeguarding, MCA/DoLS, moving and handling, equality and diversity, recruitment and dementia care. Policies were up to date and regularly reviewed at

provider level.

The home had a 'resident guide' in place. This provided people with all the information they needed about the service including the philosophy of care, registration information, who the manager was and their background, how the home was run, what was available and how to make a complaint.

We saw that there were systems in place to regularly assess and monitor the quality of the service. The home completed regular audits in a number of areas including care plans, medicines management and environmental safety. We also saw evidence of provider level auditing of both specific areas such as wound care, medicine management and the dining experience, through to comprehensive audits of service provision as a whole. All audits included action plans with timescales for completion.

The manager operated an 'open door' policy and a notice was posted on their office door identifying that anyone could speak to the manager at any time or arrange a meeting if preferred.

We saw that the manager or deputy manager completed daily walk rounds of the home in order to observe and monitor specific areas of the service. Each day a different area was looked at including provision of care, infection control, the dining experience and environment. We saw that each area was broken down into sections, for example, provision of care included food and fluid charts, staffing, interactions with people who used the service and call bell response times. The monitoring forms contained both action points and a follow up section, which reported on what had been done to address any issues.

As a further measure of quality assurance the service had installed an electronic 'tablet' at the entrance inner foyer area which was used to capture feedback from all people who experienced the service including, but not exclusive to, visiting health professionals, family and friends and staff team members.

We saw that night visit checks were completed by the home manager on a regular basis and these covered areas such as residents' care, infection control, external security, internal safety and security, medicines management, resident feedback and colleague's feedback. Information from these visits was written down and recorded and circulated to the staff team and to 'head office' for analysis. The manager also started work at a time that allowed them to meet the night staff before they finished their working shift each day, which meant that night staff were able to discuss any areas of concern face-to-face.

Accident and incident forms were completed correctly and included the action taken to resolve the issue. The service appropriately submitted statutory notifications to CQC as required and had notified CQC of all significant events, which had occurred in line with their legal responsibilities.

The service had a well-established staff team with little staff turnover and this helped to promote familiarity and develop long standing relationships between the staff group and people who used the service. The provider had introduced an exit interview tool to be completed with all staff team members as a quality assurance mechanism with the findings being used to improve conditions for existing employees. The service did not use agency staff and this was facilitated by having a robust team of bank staff.

The service worked in partnership with the local authority contracts monitoring team, with the last meeting being held in August 2015. Information we received about the service from the quality performance officer at the local authority was positive. The service also held regular meetings with the local hospice regarding the 'pilot project' and the 'hospice in your care home' initiative. A range of information was also sent each month to the health and social care information centre (HSCIC) in the form of the NHS Safety Thermometer which was used as a method for surveying patient harms and analysing results so that the service could

measure and monitor local improvement and harm free care over time.