Bondcare Willington Limited

Richmond Court

Inspection report

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Willington
Crook
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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

Richmond Court is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during the inspection.

Richmond Court accommodates up to 47 people in one building. Some people were younger adults and had a learning disability and lived on the ground floor of the service whilst older adults living with dementia and mental health needs lived on the first floor. People were accommodated over two floors and in five distinct areas, two areas on the top floor and three areas on the ground floor. The service provides residential and nursing care on the first floor and residential care on the ground floor. On the day of our inspection there were 47 people using the service.

The inspection took place on 30 April 2018 and was unannounced. This meant staff did not know we were visiting.

We last inspected Richmond Court in April 2016 and rated the service as 'Good'. At this inspection we found the service remained 'Good'.

The service had a registered manager who was on duty during the course of our visit. They had worked at the service for many years. 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.

Staff and the management team understood their responsibilities with regards to safeguarding and staff had been trained in safeguarding adults. We saw the registered manager had shared learning within the staff team from safeguarding occurrences that occurred at the service.

People's needs were assessed before they came to live at the service. Where potential risks had been identified an assessment had been completed to keep people as safe as possible. Health and safety checks were completed and procedures were in place to deal with emergency situations.

The home was clean, and we saw staff followed good practice in relation to wearing personal protective equipment when providing people with care and support.

Medicines were managed safely. We saw medicines being administered to people in a safe and caring way.

We found there were sufficient care staff deployed to provide people's support in a timely manner. We saw that recruitment checks were carried out to ensure that staff were suitable to work with vulnerable people. People told us their needs were attended to promptly.

Staff received the support and training they required. Records confirmed training, supervisions and appraisals were up to date.

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

People gave positive feedback about the meals they were served at the home. People received the support they needed with eating and drinking by the kitchen team who were trained in the support of people with nutritional needs.

The premises were homely and suitable for people's needs. People were involved in decisions about the decoration and the provider had taken steps to make the environment more accessible and personalised in response to changes in people's needs.

People had access to healthcare services in order to promote their physical and mental health. We saw that people were supported to have annual health checks and to attend health screening appointments.

People were supported by care staff who were aware of how to protect their privacy and dignity and show them respect at all times.

There were detailed, person-centred care plans in place, so that staff had information on how to support people. 'Person-centred' is about ensuring the person is at the centre of everything and their individual wishes, needs, and choices are taken into account.

An activities coordinator provided a range of activities within the home and support for people to access the community.

The provider had an effective complaints procedure in place. People who used the service were aware of how to make a complaint. Feedback systems were in place to obtain people's views about the quality of the service. We saw surveys were just being undertaken to gather people's views.

There was a quality assurance system, which enabled the provider to monitor the quality of the service provided. People and staff were positive about the management of the home.

The service was working to improve links with the local community and had recently opened a café in the grounds that was open to the public and ran by people who lived at the service.

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 remained Good.	**Good**
Is the service effective? The service remained Good.	**Good**
Is the service caring? The service remained Good.	**Good**
Is the service responsive? The service remained Good.	**Good**
Is the service well-led? The service remained Good.	**Good**

Richmond Court

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 inspection took place on 30 April 2018 and was unannounced. This meant the provider did not know we were visiting.

One adult social care inspector and a special professional advisor carried out this inspection. A special professional advisor is someone with a specialist background. On this visit our advisor was a registered nurse.

Before the inspection we reviewed the information we held about the service in order to plan for our inspection. This included the notifications we had received from the provider. Notifications are reports about changes, events or incidents the provider is legally required to let the Commission know about. We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

We contacted the local authority safeguarding and commissioning teams and the local Healthwatch. We contacted infection control leads for care homes in the area. We used their comments to support the planning of the inspection. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

During the inspection we spoke with eight people who used the service and two relatives/visitors. We spoke with the registered manager, regional director, nurse, five care staff, and the activity co-ordinator. We looked at a range of records which included the care and medicines records for four people, recruitment and personnel records for four care workers and other records relating to the management of the service.

Good

Is the service safe?

Our findings

We saw that the provider had policies and procedures explaining how staff should respond to whistleblowing and safeguarding concerns. Staff told us they knew how to recognise abuse, what action to take and how to report their concerns. Staff had received training in safeguarding and told us they were confident that the managers would act on any concerns they raised.

The provider's safeguarding log confirmed previous safeguarding concerns had been referred to the local authority safeguarding team, fully investigated and action taken to keep people safe. Action taken included additional monitoring, observation, additional training and supervision. We saw an example from a recent fire risk assessment where the assessor noted seasonal decorations had been hung above doors which may affect their ability to close fully. We saw that decorations were moved and staff reminded not to hang items above doors.

Staff members told us staffing levels were appropriate. Staff were visible throughout the home when we visited and available should people require assistance. We noted people's needs were attended to in a reasonable time frame and in a caring manner. Rotas confirmed the expected staffing levels had been maintained. Staffing levels were reviewed regularly using a specific staffing tool which considered people's dependency levels. The registered manager showed us they had recently added an additional staff member to work between 2pm and 8pm to provide additional support after they felt there was an additional need to provide this. This showed the provider reviewed staffing levels regularly.

The provider had effective recruitment procedures to ensure new care workers were suitable to work at the home. These included carrying out a range of pre-employment checks. For example, requesting and receiving two references and Disclosure and Barring Service checks. These checks were carried out to ensure prospective staff did not have any criminal convictions that may prevent them from working with vulnerable people.

The provider had systems for the safe management of medicines. We found only trained staff administered people's medicines. Records relating to the receipt, administration and disposal of medicines were completed accurately. Medicines were stored safely and checks were in place to review the appropriate storage of medicines. For example, daily temperature checks of the treatment rooms and medicine fridges helped ensure medicines remained safe to use. There were specific instructions for 'as required' medicines and also for homely medicines [such as paracetamol] saying exactly what staff could administer and in what situation and this was signed by the responsible GP.

We observed one of the senior carers giving lunchtime medicines in a sensitive and caring way. One person was reluctant to take their tablets and the staff member returned when the person was happy to take them. The situation was dealt with professionally and in such a way that the person's dignity was maintained and distress was avoided.

Health and safety related checks were carried out to help keep the premises and equipment safe for people

to use. This included checks of fire, gas and electrical safety systems as well as specialist equipment such as hoists and profile beds used when supporting people. Records we viewed confirmed these checks were up to date at the time of this inspection. Each person had a personal emergency evacuation plan [PEEPs] which detailed their individual support needs should they need to evacuated from the home in an emergency.

Risks to people were identified and managed so people were safe. This included an assessment of the level of risk and action taken to mitigate the risks to the health, safety and welfare of people. Risk assessments were completed for the environment, moving and handling, mobility, falls, nutrition and hydration, choking, continence, behaviour and skin integrity.

The registered manager told us the service had good relationships with healthcare specialists to support people's mental health and behavioural support needs. They told us, "We are well supported by the community teams, who know that if we are asking for help then we really need it as the staff do have good knowledge and skills in supporting peoples anxiety. There was evidence of formulation meetings and reviews to assist staff in managing different behaviours and situations that may be a challenge and these strategies were clearly embedded in the care plans and evaluated for effectiveness. By working in this collaborative way it ensured that the care delivery was appropriate and effective.

Incidents and accidents were logged, investigated and action taken to help keep people safe. Records showed monthly reviews of accidents were completed. This included an overview of falls within the home and action taken. For example, referrals to a specialist falls team and specialist monitoring equipment ordered and any trends or patterns.

We found the home was clean, decorated to a high standard and well maintained. Throughout our time at the home we observed domestic staff carrying out housekeeping duties to keep the environment clean. The provider completed regular infection control audits to check standards in relation to cleanliness.

Good

Is the service effective?

Our findings

All staff we spoke with told us they were provided with training that enabled them to do their job and meet people's needs. Staff mandatory training was up to date. Mandatory training is training the provider deems necessary to support people safely. This included moving and handling, health and safety, food hygiene, first aid, safeguarding, mental capacity, dignity, medicines, fire safety and infection control. Other training specific to the needs of people such as epilepsy and the management of behaviour was also provided.

New staff completed a comprehensive induction and were enrolled on the Care Certificate. The Care Certificate is a standardised approach to training and forms a set of minimum standards for new staff working in health and social care.

Records we viewed showed regular supervision sessions were carried out and staff had an annual appraisal. Supervision and appraisals are used to review staff performance and identify any training or support requirements. We saw supervisions were set on particular themes each time such as communication, personal care and medicines.

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).

People's care files had guidance for staff about asking for people's consent and we observed that staff asked for people's permission and agreement before assisting them with any support. We saw that there were records of assessments, authorisations and requests in place. We saw the registered manager maintained a register confirming where family members or next of kin held power of attorney for individuals and that documentary evidence of this had been seen. This was good practice.

We observed over the lunch time and found people were well supported to meet their nutritional needs. We observed staff were caring during lunch. They checked people were alright and whether they needed any assistance. For example, staff asked people, "Would you like any more to eat?"

We saw staff chatted to people and offered positive encouragement for people to drink for hydration and to eat their lunch. There were photographic menus in place to help people make choices about meals. Where people required specialist or adapted diets these were catered for. The service continued to maintain their Focus on Undernutrition status, a training programme carried out locally by dietitians supporting better nutrition for older people in care settings.

Staff supported people to access the health care they needed. People we spoke with advised us they had

access to external healthcare when needed such as a dentist, podiatrist or doctor. Care records showed people received regular input from a range of health care professionals, such as GPs, community nurses and specialist therapy services.

Easy read and dementia friendly signage was used to help people orientate around the home and all areas contained many personal items chosen by the people who lived there and photographs of people who used the service taking part in leisure activities.

Good

Is the service caring?

Our findings

People who used the service and their relatives gave positive feedback about the caring attitudes of staff. One visitor told us, "[Name] has been so much better since he came here and I'm so pleased about that."

One of the nursing staff told us, "The care staff are excellent. They give very high standards of care and it is the main reason I enjoy working here."

On the day of the inspection we observed staff being very proactive, always busy but also importantly having time to stop and chat and interact with people. Those people who may become distressed were having one-to-one care and careful notes and observations were being recorded but in a manner that was not obtrusive to the person's personal space.

Staff were able to share with us lots of detail about people's lives, family and previous jobs and where they had lived and they clearly knew people well. During our inspection, we saw many caring and respectful interactions between staff and the people who lived at the home. Staff had developed positive relationships with them. They did not rush people to make decisions and were led by what the person wanted to do where ever possible. People appeared at ease with the staff, looking comfortable and relaxed in their presence.

People's privacy and dignity was respected by staff closing doors when supporting people with personal care and ensuring people were supported to eat and drink when appropriate. Staff were respectful in their approach. They treated people with dignity and courtesy. Staff spoke with people in a professional and friendly manner, calling people by their preferred names.

We observed care staff assisted people when required and care interventions were discreet when they needed to be. One relative we spoke with said, "They care for [Name] so tenderly."

Staff told us they promoted people's independence, respected their wishes and gave opportunities to provide information. We saw people being supported to help with clearing dishes and there were kitchen areas in all of the sitting rooms so people could be supported to make themselves a drink if they wished.

People and relatives were involved in the care planning process. The relatives we spoke with stated that they were involved in making decisions for their loved ones and this was recorded within individual care plans. Meetings and reviews were carried out to involve people and their relatives in all aspects of people's care. One relative told us, "They keep me up to speed with everything and are on the phone if anything happens. They talk to me about everything." This meant that people and their representatives were consulted about people's care, which helped maintain the quality and continuity of care.

Regular resident and relatives' meetings were held. People were encouraged to express their views and actively supported to give suggestions to the staff team regarding their care and support.

We looked at the arrangements in place to ensure equality and diversity and to support people in maintaining relationships. Relatives told us they were given regular updates about their relative and said they could visit and ring at any time and that visiting times were clearly explained to them. One relative told us, "I cannot fault anything about the care here. They are so on the ball and keep me up to speed with everything." This showed the service supported people to maintain key relationships. We saw one person whose first language wasn't English had been supported by the activity co-ordinator using a translation device on a mobile phone to listen to music in their own language which we were told they enjoyed.

Advocacy services help people to access information and services, be involved in decisions about their lives, explore choices and options and promote their rights and responsibilities. The management team were aware of how to contact advocates if they were required to support people. We saw that information about advocacy services was available to people and was displayed on the noticeboards in the home and in information for family members to take away.

Good

Is the service responsive?

Our findings

The people and relatives we talked with told us staff were attentive and responded to their needs and requests. Their comments included, "It's fantastic, someone is always here for me" and, "I like the staff we go out together and I like that."

There were systems in place to ensure the staff team shared information about people's welfare. There was a very comprehensive handover sheet and all staff received a handover at the beginning of the duty to ensure that they have the most up to date information for caring for people. This procedure meant that staff were kept up-to-date with people's changing needs.

We saw care plans were confidentially stored and well maintained and staff recorded daily communication notes. These contained a summary of support delivered and any changes to people's preferences or needs observed by staff. This helped ensure staff had the latest information on how people wanted and needed to be supported.

A holiday was planned for some people for September and two people we spoke with told us they were, "Really looking forward to this", and had plans for buying new clothes and the activities they want to do once there. They told us, "Karaoke every night, eat out and have fish and chips and go on the beach."

We looked at four care plans belonging to people who used the service. We found care planning and the provision of care to be person-centred. Person-centred care means ensuring people's interests, needs and choices are central to all aspects of care. People had contributed to 'life history' documents in care files, which gave staff a good level of information regarding what and who was important to them. People's individual interests and preferences were taken account of including how people wished to identify themselves in relation to spiritual beliefs. The registered manager also told us, "I have added gender preference to the care plans in relation to personal hygiene and care to make sure people are comfortable with the staff supporting them."

Care plans were comprehensive and contained up to date, accurate information. We saw care plans were reviewed regularly. Care plans were reviewed and updated at least once a month to ensure they contained relevant information. Relatives we spoke with confirmed they were regularly involved in people's care planning and were updated if there were any changes in people's conditions.

There was a complaints procedure in place. There were opportunities for people and staff to raise any concerns through meetings. People we spoke with told us they knew how to make a complaint. We viewed complaint records and saw they had been comprehensively investigated and actions taken to ensure they were resolved quickly and to the complainants' satisfaction.

We met with the activity co-ordinator who showed us records they maintained of activities people participated in that recorded their enjoyment and level of involvement. They explained they undertook a lot of one to one engagement with people due to their level of dementia and also supported people to access

the community where possible. Staff members also carried out activities with people such as bingo, dominoes, arts and crafts and baking sessions.

Care records where appropriate included Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) forms, which means if a person's heart or breathing stops, as expected due to their medical condition, no attempt should be made to perform cardiopulmonary resuscitation (CPR). In the care plans we viewed, each person had a detailed plan that showed the involvement of the person and their family to record people's wishes for care at the end of their life.

Good

Is the service well-led?

Our findings

The service had a registered manager in place. A registered manager is a person who has registered with CQC to manage the service. On the day of our inspection we met with the registered manager, the regional director and nurse on duty. The registered manager had worked at the service for many years and was well known to people and their relatives.

We asked people about the atmosphere of the service and everyone said they were happy there. People told us, "I like it here, the staff are my friends," and "I like the cats and dogs," [we saw the service used therapy cats and dogs to provide comfort for people living with dementia]. Our observations were positive, with staff all communicating in a kind and friendly manner and there was fun and laughter, as well as reassurance and gentle encouragement where it was needed.

Visiting relatives both said the staff were all approachable, as was the registered manager. One relative said, "[Name] is around all the time, she explains everything very well. It's a very well run home."

We saw that people's views were sought through regular meetings, an annual survey and by the registered manager talking with people on a daily basis. People told us, and we saw from meeting minutes that actions were taken if people fed back that they weren't happy with something or they wanted a change. There was a 'You said, we did' board which showed how the service had listened to suggestions and improvements, an example was people had asked to go to Beamish Museum and this had been facilitated. This showed the service listened to people's views on how they wanted the service to run.

All staff we spoke with said they felt supported by the service's managers. Comments included, "You can approach anyone to talk, we are a good team here." We saw staff meetings took place regularly and recorded issues which included topics about infection control practices and communication. Staff member comments included, "It's a very nice caring atmosphere, not just for the people but also for each other," and a staff member who had only worked at the service for two weeks told us, "It's brilliant."

The service had good links with the local community and this was being further developed by people from the service being involved in a community café that had opened up on site and which was providing drinks, snacks and meals available to the public. The regional manager told us they wanted to take this development further by offering people training and qualifications in the future.

We looked at the arrangements in place for quality assurance and governance. We saw audits were carried out and included regular checks on medication systems, the environment, health and safety, care files, catering and falls. These audits included engaging with people who lived at the service to seek their views, reviewing care plans and complaints. We saw where deficits had been identified that actions plans were in place, which detailed a target date for the actions to be completed.

There was a robust business continuity plan and emergency contingency plan in place that had been developed in February 2018 by the registered manager and was accessible for staff to use in an emergency.

We saw that records were kept securely and could be located when needed. This meant only staff from the service had access to them; ensuring people's personal information could only be viewed by those who were authorised to look at records.

The provider was meeting the conditions of their registration and submitted statutory notifications in a timely manner. A notification is information about important events which the service is required to send to the Commission by law.