Richmond Villages Operations Limited

Richmond Village Witney

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 5 December and was unannounced.

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

Richmond village accommodates 63 people across two separate units, each of which has separate adapted facilities. One of the units Mulberry, specialises in providing care to people living with dementia. The other unit, Willow, is a nursing unit. On the day of our inspection, there were 34 people living in the home.

We were welcomed by the registered manager, village manager and staff who were happy to see us and keen to show their caring nature and share the positive changes they had made in the previous months.

Before the inspection, the provider contacted us and shared some concerns they had identified through their internal quality assurance systems. These concerns included poor medicines management, poor staffing levels, poor leadership, lack of audits, lack of staff induction and training, no comprehensive assessments and reviews as well as un-investigated complaints. The provider told us they had implemented a rescue plan which included not taking new people into the home until concerns were addressed.

We found the provider had made significant improvements to ensure people's safety. However, they were still working through their action plans and there were still some areas to improve. Where people required covert medicines, a pharmacist's guidance had not been sought. People's care plans gave details of support required, however, they were not always person centred or up to date. The provider had already identified these concerns and was working through the action plan.

People told us they felt safe living at Richmond Village. Risks to people's well-being were assessed and managed safely to help them maintain their independency. Staff were aware of people's needs and followed guidance to keep them safe. Staff clearly understood how to safeguard people and protect their health and well-being. There were systems in place to manage people's medicines. People received their medicine as prescribed.

Richmond Village continuously recruited staff to ensure people's needs were met. The home had staff vacancies which were covered by regular agency staff to meet people's needs. Same agency staff were used to maintain continuity. The management team were doing all they could to ensure safe staffing levels. The home had robust recruitment procedures and conducted background checks to ensure staff were suitable for their roles.

People had their needs assessed prior to living at Richmond Village to ensure staff were able to meet people's needs. Staff worked with various local social and health care professionals. Referrals for specialist

advice were submitted in a timely manner.

People were supported by staff that had the right skills and knowledge to fulfil their roles effectively. Staff told us they were well supported by the management team. Staff support was through regular supervisions (one to one meetings with their line manager), appraisals and team meetings to help them meet the needs of the people they cared for.

People living at Richmond Village were supported to meet their nutritional needs and maintain an enjoyable and varied diet. Meal times were considered social events. We observed a pleasant dining experience during our inspection.

People told us they were treated with respect and their dignity was maintained. People were supported to maintain their independency. The home provided information including in accessible format to help people understand the care and support that was available to them. The provider had an equality and diversity policy which stated their commitment to equal opportunities and diversity. Staff knew how to support people without breaching their rights.

The Care Quality Commission (CQC) is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) and report on what we find. The registered manager and staff had a good understanding of the MCA and applied its principles in their work. Where people were thought to lack capacity to make certain decisions, assessments had been completed in line with the principles of MCA. The registered manager and staff understood their responsibilities under the Deprivation of Liberty Safeguards (DoLS); these provide legal safeguards for people who may be deprived of their liberty for their own safety.

People knew how to complain and complaints were dealt with in line with the provider's complaints policy. People's input was valued and they were encouraged to feedback on the quality of the service and make suggestions for improvements. Where people had received end of life care, staff had taken actions to ensure people would have as dignified and comfortable death as possible. End of life care was provided in a compassionate way.

People, their relatives and staff told us they felt Richmond Village was well run. The registered manager and management team promoted a positive, transparent and open culture. Staff told us they worked well as a team and felt valued. The provider had effective quality assurance systems in place which were used to drive improvement. The registered manager had a clear plan to develop and further improve the home. The home had established links with the local communities which allowed people to maintain their relationships.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

The provider was working through an action plan to ensure medicines were managed safely.

The home had staff vacancies which were often covered by regular agency staff to meet people's needs.

Risks to people were assessed and risk management plans were in place to keep people safe.

Staff understood safeguarding procedures.

Is the service effective?

Good

The service was effective.

Staff had the knowledge and skills to meet people's needs.

People were supported to have their nutritional needs met.

Staff had an understanding of the Mental Capacity Act and Deprivation of Liberty Safeguards. People who were being deprived of their liberty were cared for in the least restrictive way.

People were supported to access healthcare support when needed.

Is the service caring?

Good

The service was caring.

People were treated as individuals and were involved in their care.

People were treated with dignity and respect and supported to maintain their independence.

Information was available to people, including in accessible formats

Staff knew how to maintain confidentiality.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's care plans were not personalised and had conflicting information.

People received activities and stimulation which met their needs and preferences.

Complaints were managed in line with the provider's policy.

People's views were sought and acted upon.

Is the service well-led?

Good

The service was well led.

People and staff told us the management team was open and approachable.

The leadership created a culture of openness that made people feel included and well supported.

There were systems in place to monitor the quality and safety of the service and drive improvement.

Richmond Village Witney

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 5 December 2017 and was unannounced. The inspection team consisted of three inspectors and two experts-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The experts-by experience's area of expertise was dementia care of the older person.

Before the inspection we reviewed the information we held about the service and the service provider. The registered 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 looked at the notifications we had received for this service. We received feedback a social and health care professional who regularly visited people living in the home. This was to obtain their views on the quality of the service provided to people and how the home was being managed. Notifications are information about important events the service is required to send us by law. We reviewed the bi-weekly reports the provider submitted as a result of their rescue plan.

We spoke with 14 people and six people's relatives. We looked at eight people's care records and seven medicine administration records (MAR). During the inspection we spent time with people. Some of the people who used the service were unable to communicate and because of this we were unable to fully obtain each of their views about their experiences. We relied mainly on observations of care and our discussions with people's relatives and staff to form our judgements. We looked around the home and observed the way staff interacted with people. We spoke with the registered manager, the village manager, the activities coordinator and staff which included a nurse, carers, the chef and domestic staff. We reviewed a range of records relating to the management of the home. These included six staff files, quality assurance audits, minutes of meetings with people and staff, incident reports, complaints and compliments. In addition we reviewed feedback from people who had used the service and their relatives.

Requires Improvement

Is the service safe?

Our findings

Before the inspection the provider contacted us and shared concerns they had identified through their internal quality assurance systems. These concerns included poor medicines management and staffing levels which were not reflective of people's needs. The provider told us, they had implemented a rescue plan which included not taking new people into the home until concerns were addressed. The provider had dismissed a number of staff and were recruiting new staff. In the meantime, they used agency staff to maintain safe staffing levels. An immediate overall review of medicines had been put in place and the registered manager was working through the action plans.

On the day of the inspection we saw the provider had a medicine policy in place which guided staff on how to give and manage medicines safely. We observed staff on Willow unit administering medicines to people in line with their prescription and the provider's medicine policy. There was accurate recording of the administration of medicines. Medicine administration records (MAR) were completed to show when medication had been given or, if not taken the reason why.

However, on Mulberry Unit we found an entry in a person's daily record indicated that they currently refused to take their medicines. The nurse on duty told us the person had refused their medicines that morning. We reviewed the person's MAR and found that the nurse had signed as having administered the person's morning medicines. We informed the registered manager who took immediate action and ensured the person's MAR was completed correctly.

We also found, where people received medicines covertly, there was no evidence of the pharmacist having been consulted to ensure that it was safe to administer the medicines in this way. Covert allows for safe administering of medicine when people are either resistant to take them or they refuse and the medicine needs to be given to them in their best interest. One person had an assessment form completed stating that covert administration had been discussed with the person's GP and a family member, who had legal power of attorney for health. However, there was no evidence of the pharmacist having been consulted to ensure that it was safe to administer the medicines covertly.

Another person had a 'Covert Medicine Assessment form' completed which indicated that the decision had been discussed and agreed with the person's GP, pharmacist and two family members. The person was administered the medicines in their food. There was no record of the pharmacist guidance that this was appropriate for the medicines to be given that way. This was not in line with national guidelines that state 'A best interests meeting should be attended by care home staff, relevant health professionals including the prescriber and pharmacist' and 'the medicines must be review by the pharmacist to advise the care home how the medication can be covertly administered safely'.

All these concerns we found had been identified through the provider's internal audits. Records showed these concerns were being addressed and reviews with healthcare professionals were planned.

Richmond Village had staff vacancies and the registered manager told us they were continuously recruiting.

The home used regular agency to cover staff shortages and this allowed continuity of care. One member of staff told us, "Staffing levels are getting better. We are using agency staff but all shifts are covered". We asked people if there were enough staff and they said, "Yes, sometimes our own staff are very good, but the agency staff are not so good", "It's hard to say, we have a lot of agency staff here" and "People do come when I press the bell, especially at night". Throughout our inspection we saw people were attended to without unnecessary delay. Call bells were answered in a timely way and staff took time to engage with people. Staff rotas showed there were enough staff on duty to meet people's needs and confirmed that planned staffing levels were consistently maintained.

The provider followed safe recruitment practices. Staff files included application forms, records of identification and appropriate references. Records showed that checks had been made with the Disclosure and Barring Service (DBS) to make sure staff were suitable to work with vulnerable people. The DBS check helps employers make safe recruitment decisions and prevents unsuitable people from working with vulnerable people. Staff holding professional qualifications had their registration checked regularly to ensure they remained appropriately registered and legally entitled to practice. For example, registered nurses were checked against the register held by the Nursing and Midwifery Council (NMC).

People told us they felt safe living at Richmond Village. People said "Yes we feel safe here. It's the carers, they are very good" and "Terrific place to live, very happy here. Feel safe? Yes". People's relatives told us, "Yes it's Safe. Carers gradually learning about [person]" and "Oh yes absolutely safe, we know a lot about Bupa".

Staff had received training in safeguarding adults and understood their responsibilities to identify and report any concerns. Staff were confident that action would be taken if they raised any concerns relating to potential abuse. Staff told us, "We report any abuse to the nurse and record in the daily records" and "We report abuse to manager, police or CQC (Care Quality Commission)". The provider had safeguarding procedures in place and records showed that all concerns had been taken seriously, fully investigated and appropriate action taken.

The provider had a whistle blowing policy in place that was available to staff across the home. The policy contained the contact details of relevant authorities for staff to call if they had concerns. Staff were aware of the whistle blowing policy and said that they would have no hesitation in using it if they saw or suspected anything inappropriate was happening. Staff were confident the management team and organisation would support them if they used the whistleblowing policy. One member of staff said, "We have a whistleblowing policy we can use".

Risks to people were identified and risk management plans were in place to minimise and manage the risks and keep people safe. These protected people and supported them to maintain their freedom and independency. Risk assessments included areas such as falls, fire and moving and handling. Risk assessments were reviewed and updated promptly when people's needs changed. For example, one person fell and sustained a fracture. The person had a sensor mat put in place to alert staff if they tried to walk without staff support. The person's falls and moving and handling risk assessments were reviewed and updated to reflect the changes.

The home had learned from mistakes. Staff told us and records of staff meeting minutes showed shortfalls were discussed with the aim of learning from them. For example, the recent internal care plan audit had identified inconsistences in recording in people's care plans. This had been discussed in debrief and staff meetings. As a result, suggestions were made to complete reflective meetings following shortfalls. We saw staff training in records was planned.

The provider had a clear procedure for recording accidents and incidents. Accidents or incidents relating to people were documented, thoroughly investigated and actions were followed through to reduce the risk of further incidents occurring. The registered manager audited and analysed accidents and incidents to look for patterns and trends to make improvements for people who used the service. Staff knew how to report accidents and incidents. One member of staff told us, "We inform the family and record on the accident form".

Richmond Village looked clean and equipment used to support people's care, for example, weight scales, wheelchairs, hoists and standing aids were clean and had been serviced in line with national recommendations. We observed staff using mobility equipment correctly to keep people safe. People's bedrooms and communal areas were clean. Staff were aware of the providers infection control polices and adhered to them. People told us the home was always clean. They said, "Lovely clean place" and "Such a clean place. Cleaners are lovely, come in everyday and talk to me".

The provider for Richmond Village had a business continuity plan and an emergency plan. These plans outlined the actions to be taken to ensure the safety of people using the service in an emergency situation.

Good

Is the service effective?

Our findings

Before the inspection the provider contacted us and shared some concerns they had identified through their internal quality assurance systems. These concerns included lack of staff induction and training. The provider told us they had put in place an action plan to review all staff induction and training.

During our inspection we found staff had mixed views regarding their induction and training provided. Staff who had been with provider from the beginning were not positive about the induction and training they had received. Staff comments included; "Induction was not good. It went too fast and was hard to follow", "I had induction for one day and did not have anyone to shadow. I had to learn as I went along" and "I shadowed for one day. There was no one to do it for longer". However, newly appointed care staff were positive the induction and training had prepared them for their roles. They went through a six month probationary period which gave them the skills and confidence to carry out their roles and responsibilities. They told us, "I had a good induction for two and half days" and "Very detailed and very good. There's more to come as well, I'm booked in for more training this week".

Records showed the induction training was linked to The Care Certificate standards. The Care Certificate is a set of nationally recognized standards to ensure all staff have the same induction and learn the same skills, knowledge and behaviours to provide compassionate, safe and high quality care and support. This included training for the role and shadowing an experienced member of staff.

Staff completed training which included safeguarding, infection control, manual handling, equality and diversity and fire safety. Staff were supported to attend specific training courses to ensure they had the skills to meet people's needs. For example, training in catheterisation. Staff told us they could request training and it would be provided. One member of staff told us, "We requested end of life training and it's being looked at".

We spoke to the registered manager and village manager about staff induction and training. They told us they had discussed with staff and agreed to offer induction and retraining for everyone who had not received a good induction. Records showed this was planned. One member of staff said, "They [management] have offered staff the opportunity to retake their training if they want to. Now a new trainer is in post and I think the majority of staff have done so".

Staff told us they felt supported and had supervisions (one to one meeting) with their line manager. Supervisions enabled staff to discuss any training needs or concerns they had. Staff said, "I feel supported. I had my supervision last month" and "I had a really good supervision last month. I have the support I need".

People's needs were assessed before they came to live at Richmond Village. This was to ensure those needs could be met. These assessments were used to create a plan of care which included people's preferences, choices and interests. People's records showed relatives and healthcare professionals were involved during assessments.

People's care records contained detailed information about their health and social care needs. Care plans reflected how each person wished to receive their care and support. For example, people's preferences about what time they preferred to get up or what food they liked to eat. Records showed people and relatives were involved in the planning of care.

People told us they received care from staff who were knowledgeable and skilled in their practice. People said, "Yes, staff seem to know what they're doing, they are good", "They [staff] work very hard. They know what they are doing. Even agency staff" and "Grateful. What they do is always right".

People's care records showed relevant health and social care professionals were involved with their care. People were supported to stay healthy and their care records described the support they needed. One person commented, "Yes, if I need to see the GP, they know the problem. I haven't seen the optician yet". The provider facilitated GP visits to review people as needed. Health and social care professionals were complimentary about the service. One healthcare professional told us, "On a number of occasions, I have communicated my concerns to staff and they have always been very keen to act and respond in the resident's best interest". People's care records showed details of professional visits with information on changes to treatment if required.

People told us they enjoyed the food and were able to make choices about what they had to eat. Comments included; "Food is very good and we get a choice. All the meals are our favourites and we never get hungry at night", "I think the food overall is very good there's always a choice and I like most things to eat" and "Menu generally good if I say don't like something they won't bring it anymore".

People's dietary needs and preferences were documented and known by the chef and staff. The home kept a record of people's needs, likes and dislikes. The home chef knew people well and was aware of their dietary needs. The chef told us they 'discussed changes to the menu based on peoples 'preferences'. Some people had special dietary needs and preferences. For example, people having soft food or thickened fluids where choking was a risk. The home contacted GP's, dieticians, speech and language therapists (SALT) as well as care home support if they had concerns over people's nutritional needs. Records showed people's weight was maintained. Drinks and snacks were available to people throughout the day.

During lunch time we observed people having meals in both the dining rooms. The atmosphere was pleasant. There was conversation and chattering throughout. People chose where they wanted to have their lunch and did not wait long for food to be served. The food was home cooked and looked appetising. People were given meal choices. On Mulberry unit people were shown two choices. We observed staff sitting with people and talking to them whilst supporting them to have their meals at a relaxed pace. We saw staff asked people if they wanted more and this was provided as needed. Some people chose to have meals in their rooms and staff respected that. People had the same pleasant dining experience despite where they were.

People or their legal representatives were involved in care planning and their consent was sought to confirm they agreed with the care and support provided. Staff sought verbal consent whenever they offered care interventions. Staff told us they sought permission and explained care to be given. For example, when people were supported with personal care. We saw a person was asked if they would like to join in with an activity. Another was asked if they would like to go to the lounge area. One person said, "Yes, I think it's the level of qualifications that some have, and they do ask me and tell me what they're going to do".

The Care Quality Commission (CQC) is required by law to monitor the application of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) and to report our findings. The 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.

The registered manager and staff followed the MCA code of practice and made sure that the rights of people who may lack mental capacity to take particular decisions were protected. People were always asked to give their consent to their care, treatment and support. Where people were thought to lack the capacity to consent or make some decisions, staff had followed good practice guidance by carrying out capacity assessments. Where people did not have capacity to make certain decisions, there was evidence of decisions being made on their behalf by those that were legally authorised to do so and were in a person's best interests. For example, where people refused personal care and had no insight on why they needed it. However staff had felt they needed more training in the MCA. One member of staff told us, "MCA training was not brilliant. We requested more training". We saw the provider had employed a home trainer and more training in MCA was planned.

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). We found the home met the requirements of DoLS. People who had DoLS in place were being supported in the least restrictive way. Staff had been trained and understood the specific requirements of the DoLS.

Richmond Village was a new purpose built home which had been decorated to a very high standard. People's rooms were personalised and decorated with personal effects, furnished and adapted to meet their individual needs and preferences. Paintings, pictures and soft furnishings evidenced people were involved in adapting their rooms. The general outlook of the home allowed free access to people who used equipment like wheelchairs.

Mulberry unit was a dedicated dementia unit. One area at the end of a corridor had been decorated to resemble a garden, with a small central tree with seating surrounding it and potted plants adjacent. There were tactile objects such as a bucket of various sized balls. A large wall cabinet called 'The Old Curiosity Shop' contained various curios, which people could engage with when lit up. However, the decoration on Mulberry unit could be improved to make it more dementia friendly. The corridors were all the same colour which could easily confuse people living with dementia, making it difficult for them to navigate their way through the home. The registered manager and village manager told us they had already recognised this and were working with the provider in improving the environment to fit the people's needs. They said they planned to use research based dementia practice to redecorate the unit and introduce more dementia staff training. The home had introduced 'dementia friends' information sessions for relatives and the wider community.

Good

Is the service caring?

Our findings

People told us received care and support from staff who were caring, compassionate and kind. They told us, "Their ethos here is to care for us and they do, and nothing is too much trouble", "Staff are very kind, some are friends no doubt about it. Responsive to my needs" and "Lovely kind caring staff".

We observed staff talking to people in a polite and respectful manner. They interacted with people as they went about their daily work stopping to say a few words to people as they passed by. People were given options and the time to consider decisions about their care. Throughout our inspection, we observed many caring interactions between staff and the people they were supporting. People's preferred names were used on all occasions and we saw warmth and affection being shown to people. The atmosphere was calm and pleasant. There was chatting, laughter and use of light appropriate humour throughout the day.

Staff had a calm approach and made sure people were comfortable. People told us staff treated them respectfully and maintained their privacy. One person said, "They always knock on my door and they always close the curtains and the door if there doing anything for me". Another person commented, "They respect my privacy, always knock or call out if the door is open". People received care in private. We saw staff knocking on people's doors and asking if they could go in. Staff told us how they protected people's dignity when giving personal care by making sure doors were closed, covering people appropriately and explaining what they were doing. One member of staff told us, "We use a 'Do not disturb' sign on the door when we are giving personal care. We close doors and curtains to maintain privacy".

Staff knew people's individual communication skills, abilities and preferences. Care plans contained information and guidance on how best to communicate with people who had limitations to their communication. We saw people who could not communicate verbally were relaxed around staff. This was visible through their body language, people smiled and their faces lit up when staff came in or met people in the corridor.

Richmond Village provided information, including in accessible formats, to help people understand the care and support that was available to them. Records showed people were involved and staff told us they knew people well and recognised when people needed help from their families. Staff told us where required they involved external help. For example, independent mental capacity advocates (IMCA). People's relatives told us the home shared information with them and they were actively involved with people's care. Records showed people's relatives had attended 'family support visits' on several occasions since. This gave them the opportunity to discuss issues around the care and support the people received.

Staff spoke with us about promoting people's independence. One member of staff said, "We do not go in and take over care. We let people and see what they are able to do". Records showed people's independence was promoted. For example, one person's record emphasised on allowing enough time for the person to try and move with minimal support. People told us they were supported to be independent. One person told us, "They [staff] encourage me to wash my hand and face and they help with my back and legs".

Staff were provided with guidance in relation to confidentiality and were aware of the provider's policy on confidentiality. One member of staff told us, "We do not share information with other people unless it's relevant". We saw staff logging on and off password protected computers. Records were kept in locked cabinets only accessible to staff.

The provider's equality and diversity policy was available in the home. This stated the provider's commitment to equal opportunities and diversity. This included cultural and religious backgrounds as well as people's gender and sexual orientation. Staff spoke to us about how they supported people. One member of staff told us, "Everyone has rights and we support that. We received the training in equality and diversity". Records showed staff had received training in equality and diversity.

Requires Improvement

Is the service responsive?

Our findings

Before the inspection the provider contacted us and shared some concerns they had identified through their internal quality assurance systems. These concerns included care plans which were not up to date or reviewed as necessary as well as complaints not investigated. The provider had put in place an action plan which the registered manager was working through.

During our inspection we found people's care plans covered areas such as personal care, eating and drinking, mobility, emotional well-being, elimination and communication needs. The care plans included information about people's personal preferences. However, we found the care plans were not always person centred and some of them were not complete and did not contain follow on information. For example, one person's wound care plan dated with a wrong date of 17 June 2016 stated actions to be taken due to a skin tear. The care plan was signed 18 June 2017. There was no follow up information to say checks had taken place and there was no wound care re-assessment completed.

Another person had been on respite and had changed to permanent care. There were no care plans completed for this person. Three more care plans we looked at were generic and did not focus on people as individuals. We asked staff if the care plans had enough information for them to give personalised care. One member of staff told us, "Our care plans are incomplete and need changing. There is a lot of work to do". Another member of staff said, "Care plans do not contain enough information. Assessments are like tick boxes".

We spoke to the registered manager about improving care plans and they told us they were aware that some of the documentation was not particularly person centred at present. The provider was in the process of updating the care plans as stipulated in their action plan. We saw that some improvements had been made and the provider was still within the action plan predicted timelines. We saw some of the incomplete care plans had been reviewed with families and healthcare professionals included in the process.
The provider had introduced a new care plan which was more person centred and easier for staff to follow. They were piloting the care plan and working with staff to review it to ensure it was fit for purpose.

People and their relatives told us they were involved in the planning of care. Records showed people's relatives had attended 'family support visits' on several occasions. This gave them the opportunity to discuss issues around the care and support the people received.

The provider had facilitated a resident and a relatives meeting immediately following identification of concerns. This gave the management team an opportunity to discuss the shortfalls that had been identified and work on an action plan based on what people wanted. This was aimed at putting people at the centre of the changes that needed to be implemented. The meeting gave people and their relatives an opportunity to feedback on what was important to them. The feedback was used to improve the care people received. For example, people suggested they would like occasional evening entertainment. Records showed this had been put in place.

The provider had a complaints policy in place which was displayed in the home and was accessible to people and their relatives. People told us they knew how to complain and were sure their concerns would be investigated and addressed. People told us, "I would go to manager. She would listen", "I have no complaints but I know the manager would look into it" and "Had a few complaints before and they were quickly dealt with". Records showed the home had received complaints and they were dealt with in line with the provider's policy. There were compliments and positive feedback received about the staff and the care people had received.

Handover between staff ensured that important information was shared, acted upon where necessary and recorded to ensure people's progress was monitored. Staff shared information about any changes to care needs, activities attended, planned appointments and generally how people had spent their day. This meant staff received up to date information before providing care, maintaining consistency.

The provider had introduced a key worker system. A keyworker is a staff member responsible for overseeing the care a person receives and liaises with families and professionals involved in that person's care. This allowed staff to build relationships with people and their relatives and aimed at providing personalised care through consistency.

The provider employed a full time activities coordinator who was supported by five activities staff who worked across the village. They told us they involved families and linked activities to people's interests and hobbies. For example, we saw a keen former Rambler was able to walk in the extensive grounds, supported by staff or a relative. Another person who liked poetry sat with a member of staff who was reading poems to them. Records showed people who enjoyed cooking had an opportunity to continue their interest in the home.

People had access to a range of group or individual activities, designed to be entertaining, improve mobility and stimulate their minds. Activities included floor games, art and crafts, singing, one to one games, cards, crosswords, word searches, exercise programmes, animal and bird visits, Bingo and reminiscence. Outside entertainers, qualified fitness staff and manicurists support the in-house programme. Peoples' spiritual needs were met. Records showed a local vicar held a communion service once a month. People can access church representatives if they wished. The home had extensive gardens which people had unlimited access to.

On the day of the inspection a local nursery school visited. On arrival they were met by two reindeers which had been hired specifically for the event. The children visited the Mulberry unit. Residents living on Mulberry unit were joined by residents from Willow unit. The children regularly visited the people and they knew them well. We saw one child hugged a person who they had interacted with before. The person's face lit up and they really enjoyed the child's embrace. The children sang a selection of their nativity carols. Afterwards they went with residents to meet the reindeers. It was a wonderful interactive activity enjoyed by everyone. Other people preferred to remain in their rooms and staff respected that and supported them in their rooms to reduce the risk of social isolation. We observed excellent staff engagement with people.

It was clear activities had had positive impact on people's well- being. For example, one person did not like to be involved in activities. Staff encouraged him to join in a musical session. The singers made such an impact on the person that they played a lead role in the home's musical. Now the person joins in with all other activities.
Richmond Village had established effective links with the local communities. Strong links had been established with the local nursery. One child who had lost her grandparents, had benefitted from the interaction and people, especially those living with the early stages of dementia who related well to the

children. Students from Abingdon and Witney College undertaking their health and social qualification had the opportunity to spend time in Richmond Village. There were plans to develop the apprenticeship scheme in the near future. People from Richmond Village often visited a local school to support pupils with basic skills and reading. This had a positive effect on people's self-esteem and pupils benefitted from the interactions. Links had been established with Rotarians and the Inner wheel fund raisers. People who were members of these organisations, living at Richmond Village continued to maintain their involvement. The home also hosted the Dementia Witney Action Alliance, Dementia Oxford, and a Dementia Café. This gave people's relatives more awareness on how to communicate effectively, interact and support people who lived with dementia. We saw people interacting with staff and their relatives positively in a dignified way. This benefitted the local community and allowed them to be involved in dementia care. Carers Oxfordshire held regular meeting and carers were invited to afternoon tea.

People's preferences relating to end of life were recorded. This included funeral arrangements and preferences relating to support. People and their relatives, where appropriate, were involved in advanced decisions about their end of life care and this was recorded in their care plans. For example, one person had an advance end of life care (a plan of their wishes at the end of life) and a do not attempt cardio pulmonary resuscitation (DNACPR) order document in place. We saw the person and their family were involved in this decision. Staff described the importance of keeping people as comfortable as possible as they approached the end of their life. They talked about how they would maintain people's dignity and comfort. The home had links with a local hospice which supported staff in providing end of life support.

Good

Is the service well-led?

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 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. The registered manager worked closely with the village manager and a regional manager.

Before the inspection the provider contacted us and shared some concerns they had identified through their internal quality assurance systems. These concerns included poor leadership and lack of audits. The provider had volunteered to send up bi-weekly updates on the action they were taking to improve the quality of the service.

During our inspection, we found the provider had been open and honest. They had been upfront regarding the concerns they had found which had resulted in a complete overhaul of the home. We reviewed the updates they had sent us in the last two months and they showed the provider had done what they said they would in the timelines they had set. It was clear the improvements were on-going but the impact of the changes to people's care was obvious. The management team had introduced new staff roles to aid their progress.

The provider had effective quality assurance systems in place to assess and monitor the quality of service provision. For example, quality audits including medicine safety, catering, infection control and care plans. Quality assurance systems were operated effectively and used to drive improvement in the service. For example, the provider's audits had identified shortfalls in leadership, medicines management and care plans. An interim registered manager and a village manager had been brought in to improve the service. Underperforming staff were managed with some dismissed. Agency staff had been brought in to ensure safe staffing levels. The provider's rescue action plan had allowed swift changes to be implemented whilst maintaining people's safety.

Richmond Village was led by an interim registered manager who was supported by a village manager and a regional manager. At the time of our inspection, the interim registered manager had only been in post for two months. We saw significant changes had been made since the registered manager's appointment. They were passionate about their role and had a clear vision to develop and improve the quality of the service.

There was a clear management structure in place, with staff being aware of their roles and responsibilities. Staff felt that they could approach the registered manager or other senior staff with any concerns and told us that management were supportive and made themselves available. The registered manager often worked on the floor and staff appreciated their hands on approach. Staff told us the registered manager and village manager had an open door policy and were always visible around the home. One member of staff said, "I see the goodness in current management and we can go to them anytime".

People, their relatives and other visitors were encouraged to provide feedback about the quality of the

service. The provider had a no blame culture which was supported by a 'Speak Up' Bupa Policy. Staff felt they could freely discuss any bad practice and knew this would be investigated and used as learning opportunities. One member of staff told us, "We have reflective meeting where we discuss any shortfalls and how we can learn from them. We are doing our best to move forward".

Staff were complimentary of the support they received from the registered manager and management team. They were appreciative of the changes and told us the current management made good changes. Staff commented, "It's heading in the right direction now. When I first started morale was quite low but (Village Manager) has arranged interviews with everybody and he definitely listens to what we say", "The new management are really approachable. I feel they are dedicated and they want it [the home] to go forward. We did not see that with the previous village manager and I felt the care home side had been forgotten" and "Manager is approachable and visible. They support us very well and they are making positive changes".

People and their relatives told us they recognised the positive recent changes and thought the current management team led the home very well. They said, "The manager is new now and comes from a much more caring background. Very easy to talk to", "We have new managers. They seem to be getting things right. We will see. They are fairly new". People commented on the recent change in home atmosphere. One person said, "A very, very friendly place, makes for a good atmosphere". People's relatives commented; "As far as visitors are concerned-welcoming" and "Atmosphere pretty good. Staff cope".

People and their relatives appreciated the effective communication they had with the home. One person's relative told us, "Keep me in touch through the communication book in room. They ring me if anything happens. We were asked 'can we ring you in the middle of the night?'".

Staff described a culture that was open with good communication systems in place. Team meetings were held where staff could raise concerns and discuss issues. Records showed discussions were around suggestions on how to improve care. The meetings were recorded and minutes made available to all staff. Staff also attended daily head of department meetings as well as 'mid shift debrief sessions'. These allowed continuous updates among staff and aimed at improving people's care.

Records showed Richmond Village worked closely in partnership with the safeguarding team and multidisciplinary teams to support safe care provision. Advice was sought and referrals were made in a timely manner which allowed continuity of care. Safeguarding audits were completed and results analysed to look for any patterns. The home was transparent and this was evidenced through their effective communication and reflective practices which aimed at improving care outcomes for people.

Services that provide health and social care to people are required to inform the Care Quality Commission, (the CQC), of important events that happen in the service. The registered manager was aware of their responsibilities and had systems in place to report appropriately to CQC about reportable events.