Richmond Painswick Limited

Richmond Village Painswick

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

Overall summary

This inspection was unannounced. When we inspected in February 2014 there were no breaches of legal requirements.

The Richmond Village Painswick provides accommodation and nursing care for up to 24 people. The nursing home is on the same site as 42 assisted-living flats and independent homes. At the time of our inspection there were 24 people in residence.

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

The staff team, including the registered manager had received safeguarding adults training so understood their role and responsibilities to protect people from harm.

Summary of findings

Staff were provided with information telling them what to do if they needed to raise safeguarding concerns with other agencies. There have been no safeguarding concerns raised.

Risks in respect of people's daily lives or their specific health needs were assessed and appropriately managed. Plans were in place to reduce or eliminate those risks. Regular checks of the premises, facilities and equipment were undertaken to ensure they were maintained in good working order.

The staffing numbers for each shift were based upon the collective care and support needs for each person and these were adjusted when people were unwell. This ensured people were kept safe and their care needs were met. Staff were provided with regular training and opportunities to develop their skills further. They had the necessary knowledge and skills to meet people's individual care needs.

Staff were aware of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). They ensured people consented to any care and support provided. The service had not needed to submit any applications to deprive a person of their liberty. Relevant staff had been trained to understand when an application should be made, and in how to submit one. This meant that people were safeguarded as required.

People were provided with sufficient food and drink, or dietary supplements to meet their requirements. Where people were at risk of poor diet and fluid intake, measures were in place to monitor how things were going. There were regular meetings with the catering team and feedback from people about the meals served was welcomed. Arrangements were made for people to see their GP and other healthcare professionals as and when they needed to do so.

People said the staff were kind to them and they were looked after. Staff spoke about the people they were looking after in a kind and respectful manner and ensured they delivered care in the way the person liked. People were involved in making decisions about how they wanted to be looked after and how they spent their time. People's privacy and dignity was maintained at all times.

People's individual needs were met because everyone was looked after in a person-centred way. They were encouraged to have a say and to express their views and opinions about their care, the way the home was run and activities that took place. Staff listened to what they had to say and acted upon any concerns to improve the service they provided.

The registered manager provided good leadership and had a committed staff team who provided the best possible service to each person who lived there. The quality of service provision and care was continually monitored and where shortfalls were identified actions were taken to address the issues.

Summary of findings

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 was safe.

People were kept safe from harm because staff were aware of their responsibilities and would report any concerns. All staff received safeguarding training. Staff recruitment procedures were safe and ensured unsuitable staff were not employed.

Risks were well managed and enabled people to be as independent as possible. Medicines were well managed and people received their medicines as prescribed.

Good

Is the service effective?
The service was effective.

The staff were well trained and had the necessary knowledge and skills to be able to look after people effectively.

The service was meeting the requirements of the Deprivation of Liberty Safeguards (DoLS). When necessary the appropriate steps would be taken to ensure the correct authorisations were in place. People's rights were properly recognised, respected and promoted.

People had enough to eat and drink and their specific requirements were accommodated. Measures were in place to monitor and manage people's needs where there was a risk of poor nutrition or dehydration.

People's health care needs were met and staff ensured the GPs and other healthcare professionals were involved in people's care when needed.

Good

Is the service caring?
The service was caring.

People were looked after by staff who were kind and caring. Staff provided the support people needed and treated people with dignity and respect.

Good

Is the service responsive?
The service was responsive.

People received the care and support they needed. They were involved in having a say about how they wanted to be cared for. Where this was not possible, their families were included in the decision making process.

The staff team were aware of people's preferences, likes and dislikes.

People were encouraged to speak out when they wanted things to change.

People were able to participate in a range of different in-house activities and were given the opportunity to feedback on the things they would like to do.

Good

Is the service well-led?
The service was well-led.

Good

Summary of findings

The service was well run. All staff were committed to meeting each person's individual needs in a person-centred way. The registered manager provided good leadership and also provided 'hands on support'.

Monitoring systems were in place to ensure that a quality service was provided to each person. Any comments or complaints people made were listened to and acted upon appropriately. Where any shortfalls were identified there were improvement plans in place and appropriate action was taken.

Richmond Village Painswick

Detailed findings

Background to this inspection

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

The inspection team consisted of one adult social care inspector.

Prior to the inspection we looked at the information we had about the service. This information included the statutory notifications that the provider had sent to CQC. A notification is information about important events which the service is required to send us by law. We reviewed the Provider Information Record (PIR) and previous inspection reports before the inspection. The PIR was information given to us by the provider. This is a form that asks the provider to give some key information about the service, tells us what the service does well and the improvements they plan to make.

We contacted four healthcare and social care professionals as part of the planning process and the feedback we received has been incorporated in to the main part of the report.

During the inspection we spoke with 10 people who live in the home, three relatives and seven members of staff including the registered manager.

We looked at four people's care records, four staff recruitment files and training records, staff duty rotas and other records relating to the management of the home.

Good

Is the service safe?

Our findings

People said, "I have no worries about my safety, I have always been treated with the utmost kindness. No one here has ever been horrible to me", "I am not worried about anything" and, "I would speak up if anyone behaved badly towards me. You read about awful things in the paper, but there is none of that here". Relatives we spoke with said, "We believe our relative is very safe", "I have no concerns when I leave the home and know that my relative will be well looked after at all times" and, "I have no concerns about how X is looked after".

All staff completed safeguarding training as part of the essential training programme. The training was delivered by a computer based learning programme. Staff we spoke with had a good awareness of safeguarding issues and would report any concerns they had about people's safety to the registered manager or the nurse in charge. Staff also knew they could report directly to Gloucestershire County Council safeguarding team, the Care Quality Commission or the Police.

The registered manager had attended the advanced safeguarding adults training with Gloucestershire County Council and had a good understanding of safeguarding issues.

Risks assessments were completed for each person in respect of the likelihood of falls, use of bed rails, nutrition, moving and handling tasks, continence and the likelihood of developing pressure ulcers. A safe system of work was devised for those people who needed assistance to move or transfer and these detailed the equipment required and the number of care staff to undertake any task. Other person-specific risk assessments had been completed, for example, to minimise the risk of choking. Personal emergency evacuation plans (PEEP's) had been prepared for each person: these detailed what support the person would require in the event of the building needing to be evacuated in the event of fire or other emergency.

Checks of the premises, facilities and equipment were undertaken on a weekly or monthly basis. The home manager maintained an oversight that these checks had been completed. This ensured that the premises and all equipment remained in good working order.

Staff files were checked to ensure safe recruitment procedures had been followed to prevent unsuitable staff being employed. Each file evidenced that appropriate pre-employment checks had been undertaken. Disclosure and Barring Service (DBS) checks had been carried out for all staff (previously called CRB's. A DBS check allows employers to check an applicant's police record for convictions that may prevent them from working with vulnerable people. References were obtained from previous employers

On a monthly basis the dependency score of each person was reviewed and rated as high, medium or low needs. These scores were used to calculate the staffing numbers for each shift. Shifts were covered with a mix of management, ancillary staff, nurses and care staff. A nurse was on duty for every shift including weekends and overnight. Each day there was one qualified nurse on duty and three or four members of care staff. Overnight there was one nurse and three care staff (the third member of staff provided planned domiciliary cover and on-call support to people in the assisted living suites on the same site).

Staff felt staffing numbers were appropriate. At least one qualified nurse was on duty at all times. The staff team was made up of seven qualified nurses and 15 care staff and staff generally did a 12 hour 8am-8pm shift during the day (or a half day in the mornings). There were currently two qualified nurses for the day shift and one overnight. Five or six care staff were rota'd to work in the mornings with four in the afternoons and evenings. Staff said shifts were always well covered. The registered manager always liked to cover some shifts and this included night duties. There were a number of nurse vacancies and agency staff were being used. The registered manager ensured that the same agency staff were provided and this was confirmed by checking the staff rotas for the last four weeks. People were looked after by staff who were familiar with their needs and preferences. The service had an on-going recruitment drive in place in order to reduce the reliance upon agency staff and planned to introduce enhanced senior care staff who would receive additional training in order to undertake some clinical tasks.

Each person was supported with their medicines. All medicines were looked after and administered by nurses at the prescribed times. Medicines were re-ordered on a four weekly basis to ensure they were always available. New supplies were checked against the printed medicines administration record (MAR) charts. We were told that the

Good

Is the service safe?

nurses do not see the GP prescription forms because they do six monthly prescriptions and these were kept by the pharmacist. GPs reviewed people's medicines on at least a six monthly basis.

All medicines were stored safely in a well ventilated locked room. A medicines refrigerator was available for those medicines that required cold storage and appropriate arrangements were in place for storing controlled drugs. Nursing staff checked the stock balance of the controlled medicines on a weekly basis. Where people were prescribed creams or ointments, a topical medicines record was kept in their bedroom and the treatment was applied by the care staff.

Good

Is the service effective?

Our findings

People made the following comments: “I get all the help I need”, “I do get worried at times and all the staff reassure me and help me relax”, “The staff are all very good at their jobs”, “Nothing is too much trouble and any request I make is always met” and, “I get the exact help I need. The care staff know how I like things done”. Relatives said, “I am very satisfied with the care and attention paid to my relative”, “All the staff are well trained and competent” and, “I have nothing but praise for all the staff here. They all do their jobs well”.

Staff were supported to do their jobs. New staff completed an induction training programme that met the requirements of the Care Certificate at the start of their employment. There was a two day ‘corporate’ induction programme that included moving and handling, fire awareness, safeguarding and deprivation of liberty safeguards. The new recruit then had an induction training programme to complete within 12 weeks that was based upon their job role There was a mixture of on-line training, workbooks to complete as part of a knowledge check and practical assessments. All staff then had an on-going programme of mandatory training to complete. This included health and safety and fire awareness, infection control, safeguarding adults and moving and handling training.

Staff received a regular supervision session with a senior member of staff and an annual appraisal. Staff confirmed they had a regular supervision session and they talked about their work performance, any welfare issues and any training and development needs. Records were maintained of all supervision sessions. Nurses told us they were provided with opportunities to do clinical training in order to meet the conditions of their registration with the Nursing & Midwifery Council (NMC).

Care staff were encouraged to complete recognised qualifications in health and social care. Of the 15 care staff, 10 had a qualification at level two or were working towards the award and others had commenced the level three award.

Staff completed Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS) training. Staff were able to talk about what would happen if a person lacked mental capacity and what they would do if a person did not consent to receive care and support. They knew how best interest decisions should be recorded and who should be involved in the process. During the inspection we heard the staff asking people to give their agreement to things that affected their daily lives. Examples of this included, what they wanted to eat, whether they wanted assistance to get out of bed and whether to participate in social activities.

The registered manager was knowledgeable about the MCA and DoLS and knew CQC needed to be notified when the outcome of any applications were known. MCA legislation provides a legal framework for acting and making decisions on behalf of adults who lack the capacity to make decisions for themselves. DoLS is a framework to approve the deprivation of liberty for a person when they lacked the capacity to consent to treatment or care. The safeguards legislation sets out an assessment process that must be undertaken before deprivation of liberty may be authorised. It also details arrangements for renewing and challenging the authorisation of any deprivation of liberty. No DoLS applications were necessary at the time of our inspection. The registered manager told us about a couple of occasions when she had checked out with the local authority whether a DoLS application was required.

As part of the assessment process of each person’s care and support needs, an assessment of their mental capacity was carried out. This was in respect of all aspects of care and daily living. These assessments would be reviewed when there were changes in the person’s needs. Where people were assessed as lacking the capacity to make specific decisions, a process of best interest decision making was undertaken and recorded. This process involved key people such as, family members, the person’s GP and other health care professionals.

People’s nutritional needs were assessed to determine any risk of malnutrition and the catering staff were notified where risks had been identified. The catering staff were informed of any food allergies and dietary needs. They provided fortified foods for those people who had low BMI’s (body mass index) or had significant weight loss. Meetings were held on a three monthly basis with the registered manager, or one of the nurses and the senior catering team. Items for discussions in the last meeting had included the menus, the temperature of meals served to people in their own rooms, pureed and soft diets and the visual photos of dishes to be served. As part of the care

Good

Is the service effective?

planning process an eating and drinking care plan was written for each person. Where risks were identified, the plan incorporated the measures to be taken to manage that risk. The plans included any instructions given by the GP or other healthcare professionals. Monthly body weights were recorded for everyone, weekly for those people at risk of weight loss. Food and fluid charts were maintained where a person's eating and drinking needed to be monitored.

People made positive comments about the meals they were served with. People said, "The meals are really rather good", "If we don't want either of the planned meals at lunch time we can always ask for something else" and, "The choice of meals is very good and there is always something I like". People were served their meals either in the dining room or in their own room.

Each person was registered with a local GP practice. One of the GPs visited every two weeks on a Wednesday and saw those people the nurses had identified as needing a GP visit. Nurses also requested GP visits when people were unwell or when people had asked to see their doctor. We offered the GP practice the opportunity to provide us with feedback about how their patients were looked after. They commented that they had "no concerns".

Arrangements were in place for people to receive support from visiting opticians, dentists and chiropodists. The home worked alongside community and hospital social workers, occupational therapists and physiotherapists in order to make sure people were well looked after.

Good

Is the service caring?

Our findings

People said, “The staff are kind to me”, “I can be a bit grumpy at times but I couldn’t be any better looked after”, “I used to live in another care home. It is much more friendly here” and, “The staff help me with everything and are always so accommodating”. Relatives said, “The staff are so kind and caring. We cannot fault a thing” and, “We visit very regularly and have always found things to be spot on. All the staff are wonderful”.

Staff spoke about people in a kind and respectful manner and were aware of the different way people liked to be looked after. Staff addressed people in an appropriate manner, generally by their first name. Where people wished to be referred to by their formal title, this was respected by the staff team. This preference was recorded in their care plan. Staff received training in equality and diversity and this enabled them to provide support that took account of each individual’s needs and wishes.

During our visit we observed a number of different occasions of positive interaction between people and the staff. On one occasion a member of staff was having a conversation with a person about the ornaments in their bedroom and the person was saying who bought it for them, whether it was a birthday or Christmas present and whether they actually liked it. On another occasion we watched whilst the care staff made a person comfortable and although the person could not communicate verbally, the staff chatted away with them. One person, who said they did not feel well and was very anxious was reassured gently by the care staff.

A document called ‘This is Me’ had been completed with each person. Those we saw had different amounts of information recorded. These documents recorded the person’s history, their personal preferences, family background, social preferences and hobbies. Each person had a key worker and named nurse in order to promote continuity and familiarization for the person and their family. Care staff were able to tell us about the people they were a keyworker for. This showed people received care and support from staff who knew them well.

Good

Is the service responsive?

Our findings

People told us, “I get all the help I need. If I am not feeling too special in the morning, I have a lie-in and get up a bit later”, “All the staff are very accommodating. I don’t want for anything here”, “When I use the call bell for assistance, the staff come and help me quite quickly” and, “The staff help me whenever I need support and are very helpful and kind”. Relatives said, “We can’t fault the love and care. Our relative is extremely well looked after” and, “The staff are very patient with our mother and she is very well attended to”.

People’s care needs were assessed prior to admission to the home. This ensured the service was appropriate for the person, the staff had the required skills and experience and any specific nursing equipment was available. Information gathered in the assessment process was used to develop a personalised care plan for each person. These plans included people’s likes and dislikes and what was important to that person. They also provided details about people’s personal care needs, their mobility, the support they needed with eating and drinking, managing continence and wound care management where required.

The care plans we looked at were clear and appropriately detailed. Care plans evidenced that the person and their families were involved in the process and they were looked after in the way they liked. Where people had wounds that needed to be tended to, there was evidence of specialist tissue viability nurse involvement and regular photography had recorded the progress of the treatment. The staff had recorded an evaluation of the wound each time they had renewed the dressings. One person’s nutrition and hydration plan stated they were on an enteral feeding regime (fed by a gastric tube directly in to the stomach). There were clear instructions for the nursing staff to follow.

Where decisions had been made regarding a person’s wishes in the event of a sudden collapse, improvements were required in the way this information was recorded. In the main nurses office there was a white board with a list of people. Where a Do Not Attempt Resuscitation (DNAR) decision had been made this was recorded in red by their name. In two people’s care file however, the appropriate documentation had been completed by a hospital consultant and not the healthcare professional (normally a GP) who was responsible for their care. For others where decisions had been made about end of life care the GP’s had completed and signed an ‘Allow a Natural Death’ yellow sticker. These were not always placed at the front of the care records. These forms have however, been replaced with formal nationally recognised Resuscitation Council forms (approved for use across all care settings). These forms allowed any consultations with relatives to be recorded along with the members of nursing staff included in the decision-making process. The registered manager agreed to review the documentation with the GP for all those people where decisions had already been agreed.

There were members of staff responsible for arranging a programme of activities for the people. They were supported by a number of volunteers. One of the volunteers was present in the afternoon and started a ‘knit and natter’ session with a group of five ladies. In the morning there had been a gentleman's group and approximately six men took part. One person said, “I have to really like something to go along. I like to spend my day knitting on my own”. Another person said, “I like being in the lounge all day and watching TV. I avoid all the activities but I know what is going on”. There was a wide range of activities arranged. There was a daily ‘wake and shake’ session. The programme for the week included creative writing, arts and crafts, flower arranging, a church service for all denominations and music appreciation. As well as activities that were arranged for the people who lived in the nursing home, there were activities arranged by the village and reported in the Social Diary – a leaflet that was distributed to each person and displayed on the noticeboard.

People and relatives we spoke with felt able to raise any concerns or complaints with the care staff, nurses or the registered manager. One person said, “I have absolutely no complaints but I would certainly speak to the top person if I did have”. People were asked to share their views or make comments about things during their care plan reviews, resident and relative meetings and at any time they wanted to make comments.

Good

Is the service well-led?

Our findings

People said, “The home is very well run and all the staff have high standards”, “We see the manager very regularly”, “I would want you to give this home a good report because it is the best” and, “Everything runs smoothly and I am looked after very well”. Relatives said, “We are very pleased that X lives here. We were impressed with the staff and the manager when we came to have a look around”.

Staff said the registered manager provided good leadership and had high standards which they were all expected to meet. They said that the manager often did nursing shifts and worked with them to meet people’s care and support needs.

The registered manager was supported by the village manager and an area manager, nurses and a team of care and ancillary staff. A short meeting was held each morning with the village manager and other heads of department and senior staff. This meeting was used to discuss any issues that were relevant regarding the premises, staffing, changes in people needs and visits from outside organisations that were planned.

In the service’s statement of purpose it stated it was their mission to offer the highest quality of care, service and environment for not only the people who lived there but also all visitors. The aim was to ensure that people had longer, healthier and happier lives. From speaking with the registered manager and the staff, this was the aim of all who worked at the service.

There was a programme of staff meetings scheduled for the rest of the year. Monthly meetings were held with the qualified nurses and two monthly meetings were held with the whole care team, day and night staff. Meeting notes were recorded following all meetings and shared with those staff who had been unable to attend. Resident and relative meetings were held twice a year and the last meeting had been held on 23 May 2015. Discussions had been about care plan reviews, activities and the meals served. The new hospitality manager had attended this meeting and had talked about the improvements planned for the catering service. The registered manager attended regular meetings with other home managers, village managers and the area manager.

The registered manager had to complete monthly and quarterly ‘metrics report’. The last quarterly report had been submitted in June 2015 and was designed to assess the quality of care, the quality of life for people, the quality of leadership and management and the quality of the environment. The assessment referred to the number of home acquired pressure ulcers, nutrition and weight loss, the number of deaths, medication errors and the use of anti-psychotics in the home, GP reviews, hospital admissions and infections, safeguarding referrals and DoLS applications, accidents and incidents and any concerns or compliments received.

The provider had a programme of audits and quality checks. Some were completed by the staff or the registered manager and others were undertaken by senior managers from other services run by the provider. In February 2015 a full audit had been undertaken in respect of medicines management but also involved conversations with ‘residents’ and relatives, staff, observations following a tour of the premises and all the issues referred to in the quarterly reports. In May 2015 a full audit had been completed in respect of care documentation. Each of these audits had resulted in an action plan where improvements were required. At the following audit the senior manager reviewed the action plan.

The home manager was aware of when notifications had to be sent in to CQC. A notification is information about important events which had happened in the home the service is required to send us by law. The CQC used information sent to us via the notification process to monitor the service and to check how any events had been handled.

The registered manager saw all accidents and incidents forms. On a monthly basis the registered manager reviewed all reports in order to identify any trends. This meant that preventative action could be taken to reduce or eliminate a reoccurrence.

A copy of the complaints procedure was included in the homes brochure given to each person and also displayed on noticeboards in the reception area and in various places throughout the home. The procedure stated that all complaints would be acknowledged, investigated and responded to within a 28 day period. In the previous 12 months the service had received nine complaints and each had been dealt with in accordance with the complaints procedure. The registered manager analysed information from complaints in order to identify any themes. As a result issues regarding communication and relationships with

Good

Is the service well-led?

families had been identified and addressed. Two of the formal complaints raised were about the standard of personal care provided therefore personal care training sessions had been arranged.

Since the beginning of 2015, the service had received 11 complimentary letters from people who lived in the home or from the families of people who had used the service. Staff told us they were always informed when feedback from relatives had been received.

A care home satisfaction survey had been completed in 2014 and 20 people had participated. Eighty-nine percent of the people that responded were overall satisfied with the quality of the service. People were asked to comment about the staff, the catering service, the social life within the home, the environment and facilities and the atmosphere within the home. Where the service had not scored as well as they could, an action plan had been compiled detailing what actions would be taken to make improvements.