Bondcare Willington Limited

Richmond Court

Inspection report

Hall Lane
Willington
Crook
County Durham
DL15 0PW

Tel: 01388745675
Website: www.bondcare.co.uk/richmond-court/

Date of inspection visit:
12 June 2023
27 June 2023
03 July 2023

Date of publication:
23 August 2023

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Richmond Court is a residential care home providing personal and nursing care to 42 people at the time of the inspection. The service can support up to 49 people. The home accommodates people with a learning disability and/or autism on the ground floor. On the first floor, nursing care is provided to people, many of whom are living with dementia.

We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it.

People's experience of using this service and what we found
Right Support: Medicines were not always managed safely. Systems did not always show staff how and when to give medicines, and medicines were not always stored safely. Risks in the environment and people's personal risks had not always been assessed so that action could be taken to reduce these. Systems in the home did not always ensure people's dignity was promoted. People were supported to have choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice. There were, however, some inconsistencies in the way people's capacity and consent were recorded and decision making was not always clearly documented. People and relatives told us they felt the service was safe. Accidents and incidents were recorded, and actions taken to reduce the chance of them happening again.

Right Care: People did not always receive care that supported their needs and aspirations, and focused on their quality of life, and followed best practice. Although there had been some recent improvements the provider had not fully acted on feedback given at the last inspection to ensure care was truly person-centred. People with a learning disability were accessing the community and taking part in more skill building activities but there was not always evidence these were planned to meet people's long-term goals or improve their outcomes. There had been recent training around positive behavioural support, a person-centred approach to supporting people with a learning disability, and training on methods of communication people in the home used.

There were enough staff to meet people's needs. People and most relatives told us there were staff available to meet their needs quickly but there was some mixed feedback about the level of engagement on offer. The provider had appointed a new activities co-ordinator and was offering more social support. People were kept safe from avoidable harm because staff knew them well and understood how to protect them from abuse. The service worked well with other agencies to do so.

Right Culture: An effective quality monitoring system was not in place. We identified shortfalls relating to the

management of medicines, the assessment of risk including environmental risks and inconsistency in people's care records, including around consent and capacity. Practices in the home did not ensure people's dignity was always promoted. Systems had not ensured CQC was always notified of incidents in the home.

People gave positive feedback about the caring nature of the service. Staff spoke positively about the service and the management. Feedback was sought and acted on. Relatives and staff described the registered manager as approachable and responsive to any issues raised. The management team were honest and open with us during the inspection. They exhibited caring values and spoke positively about the changes and improvements which were being made. The registered manager had sought advice and support from specialists within the organisation as well as being part of wider networks on good practice.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection and update
The last rating for this service was requires improvement (published 16 June 2022). The service remains rated requires improvement. This service has been rated requires improvement for the last 2 consecutive inspections.

The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found the provider remained in breach of regulations.

At our last inspection we recommended that the provider ensured suitable staffing levels were maintained. At this inspection we found the provider had acted on this recommendation and had made improvements in relation to staffing.

Why we inspected
We carried out an unannounced comprehensive inspection of this service on 4, 16 and 25 February 2022 and 4 March 2022 and breaches of legal requirements were found. The provider completed an action plan after the last inspection to show what they would do and by when to improve safe care and treatment and good governance.

We undertook this focused inspection to check they had followed their action plan and to confirm they now met legal requirements. This report only covers our findings in relation to the Key Questions Safe and Well-led which contain those requirements.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service has remained requires improvement. This is based on the findings at this inspection.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Richmond Court on our website at www.cqc.org.uk.

Enforcement and Recommendations
We have identified breaches in relation to medicines management, safety of the premises, assessing risk,

dignity, and good governance at this inspection.

Please see the action we have told the provider to take at the end of this report. Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

At the last inspection we made a recommendation about staffing. At this inspection improvement had been made and the recommendation had been met.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

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.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Richmond Court

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out by 2 inspectors and a specialist nurse advisor. An Expert by Experience made telephone calls to relatives. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Richmond Court is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Richmond Court is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager in post.

Notice of inspection

This inspection was unannounced. We gave 24 hours' notice of the second day of the inspection. This was because we wanted to give the provider or registered manager opportunity to be in the home to support the inspection. Inspection activity started on 12 June 2023 and ended on 3 July 2023. We visited the location's service on 12 and 27 June 2023. We continued to speak with professionals and receive information from the provider until 3 July 2023.

What we did before inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with 5 people. Some people who used the service had difficulty communicating, however, we spent time observing people's daily experiences of the care and support provided. The Expert by Experience spoke with 11 relatives about their experience of the care given.

We gathered feedback from 16 members of staff including the registered manager, regional manager, deputy manager, activity coordinators, maintenance person, nurse, senior care staff and care staff. We reviewed a range of records. This included 7 people's care records and 17 medication records. We looked at 2 staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At our last inspection we rated this key question requires improvement. The rating for this key question has remained requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Using medicines safely

At our last inspection the provider had failed to manage medicines safely. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

- Medicines were not always managed safely. Staff were not always given clear guidance about how and when to administer people's medicines.
- There was a lack of guidance for certain medicines which were prescribed as a variable dose or on a 'when required' basis or covertly (medicines that can be given without people's knowledge). There were also shortfalls around people's topical medicines records (such as for creams applied to skin).
- Medicines were not always stored or checked in a robust way, and this had resulted in out-of-date medicines being administered to one person.

Medicines were not administered or managed safely. We found no evidence that people had been harmed, however, this was a continued breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

After feedback the provider told us how they would address the shortfalls identified. We will review how this is embedded in to practice at the next inspection.

- Staff understood and implemented the principles of STOMP (stopping over-medication of people with a learning disability, autism or both) and ensured that people's medicines were reviewed by prescribers in line with these principles.

Assessing risk, safety monitoring and management

At our last inspection the provider had failed to robustly assess the risks relating to the health, safety and welfare of people. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of

regulation 12.

● Risks were not always managed safely. Several areas of the home which should have been secured were open. This included key-coded doors leading to different parts of the home and garden. Storage cupboards, bathrooms, and a sluice room (a room for storing and washing items, such as those used for human waste) were left unlocked. Some of these areas contained hazardous items.
● People did not always have risk assessments to reflect current risks. For example, one person was identified as having fire risks in their bedroom but there was no documented assessment of these, or the action taken to reduce the risks.

We found no evidence that people had been harmed, however, systems were either not in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

After feedback the provider told us how they would address the shortfalls identified. We will review how this is embedded in to practice at the next inspection.

Preventing and controlling infection
● Systems to reduce and prevent the spread of infections were not always robust. Various personal items, toiletries and a duvet were stored in communal bathrooms. This increased the risk of the spread of infections.

This was breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

After feedback the provider told us how they would address the shortfalls identified. We will review how this is embedded in to practice at the next inspection.

● The home had policies around preventing and controlling infections and staff were trained in safe ways of working. Cleaning schedules were in place and the home was kept clean.
● The provider's visiting policies and procedures adhered to current guidance.

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 MCA 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 Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)
● We found the service was working within the principles of the MCA and, if needed, appropriate legal authorisations were in place to deprive a person of their liberty. Any conditions related to DoLS authorisations were being met. Records about people's level of capacity and consent were, however, inconsistent and did not always document how decisions were made to support people in the least restrictive way.

This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
At our last inspection we recommended the provider reviewed staffing levels in line with current best practice guidance and considering the needs of the people using the service.

At this inspection enough improvement had been made and the recommendation had been met.
● There were enough staff in the home to meet people's needs. We observed staff meet people's needs and received feedback from people that staff were available when they needed assistance.
● We received mixed feedback from relatives about how much staff engaged with people. One relative told us, "[Person] is safe, but I don't think they are checked regularly enough. When I visit it is a long time before anybody comes to see me." Another told us, "[Person] is in a safe place. The staff are second to none. I have very high views and there are no faults." There had been a recent increase in staff supporting activities to offer people more engagement.
● Staff were recruited safely. Recruitment checks were carried out before staff were appointed.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong
● Systems were in place for staff to report concerns and incidents and these were acted on. People and relatives told us they felt staff kept people safe. Staff were trained in safeguarding and knew how to recognise the signs of abuse.
● Systems were in place to monitor accidents and incidents to look for any patterns or trends. Lessons learnt and actions for improvement were shared with staff.

Requires Improvement

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question requires improvement. The rating for this key question has remained requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

At our last inspection the provider had failed to have effective systems in place for checking on the quality and safety of the service. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

● The systems for checking on the quality and safety of the service were not always effective. Audits failed to identify the concerns highlighted on this inspection, for example, medicines management and assessing and reducing risks both to individuals and in the environment.
● Care records did not always accurately reflect people's needs and were not consistently updated when their needs changed.
● Whilst new training, systems and procedures had been introduced since our last inspection, further action was required to ensure the improvements made were sustained and embedded into practice.

Systems were not robust enough to oversee the quality of the service. This placed people at risk of harm. This was a continued breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

An effective system was not fully in place to ensure events at the service were notified to CQC in line with legal requirements.

The failure to ensure CQC were informed of notifiable events at the service is a breach of Regulation 18, Notification of other incidents. We are dealing with this issue outside of this inspection process.

● The new registered manager had driven improvements in some areas of the service since they came in to post. For example, staff now had medicines competency checks and more service specific training had been completed.
● Staff told us they felt supported in their roles.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

● The culture in the home did not always ensure people's dignity was promoted. Some towels in use were not fit for purpose. They were faded, ripped, stained and threadbare. Some activities on offer were not age appropriate and used resources designed for young children.

People's dignity was not always promoted. This was a breach of regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● There was little documented planning for the whole life of people with a learning disability to ensure they achieved good outcomes over time. Since the last inspection staff had begun to support people to be more independent, however, this was not always done in a person-centred way considering the person's skills.

●Staff told us there was a positive atmosphere in the home, with staff and management working together to develop the service. One staff member told us, "With the new management people are a lot happier, it's much brighter. Massive changes. Everyone is more positive. The manager communicates with everyone, solves problems straight away." Feedback from some relatives also reflected that there had been recent positive changes.

● Management staff were honest and open with us during the inspection. They exhibited caring values and spoke positively about the changes which were being made in the home.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Continuous learning and improving care; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● The provider engaged with people, relatives, and staff in several ways such as: questionnaires, residents' meetings and keeping people updated about their loved one's care. Comments on the service were acted on and the outcomes were displayed in the home.

● Staff had regular meetings, and key staff met daily with the registered manager. Staff told us they felt involved in the running of the service and could make suggestions for improvement.

● The registered manager understood their responsibilities around duty of candour.

Working in partnership with others

● The registered manager and their staff team worked with external health and social care professionals sharing information and assessments to inform and improve the quality of care.

● The registered manager was involved with external networks to share good practice and had support from in-house specialists.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect Systems did not ensure people were always treated with dignity and respect. This was a breach of regulation 10(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Medicines were not safely managed 12(2)(g) Risks to people's health and safety were not correctly assessed and mitigated. 12(2)(a)(b)(d) This was a breach of regulation 12(1)(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance System did not always assess, monitor and improve the quality and safety of the services, mitigate risk to health or ensure records were accurate, complete and contemporaneous. This was a breach of regulation 17(1)(2)(a)(b)(c)(d)(ii)(f), of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

Issued Warning Notice