Innocare Limited

Riverslie

Inspection report

79 Crosby Road South
Waterloo
Liverpool
Merseyside
L21 1EW

Tel: 01519283243
Website: www.innocare.co.uk

Date of inspection visit:
21 July 2022
27 July 2022

Date of publication:
23 November 2022

Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Riverslie is a care home providing accommodation, personal and nursing care for up to 30 people; some of whom lived with dementia and physical disabilities. At the time of our inspection 22 people were living at the service.

People's experience of using this service and what we found
Risk to the health, safety and welfare of people and others had not been assessed, monitored and managed, placing them at serious risk of harm. We found a catalogue of serious concerns relating to the safety of both the inside and outside of the premises, utilities, equipment and preventing, detecting and controlling the spread of infections.

The systems and processes for assessing the quality and safety of the service failed to identify things that had gone wrong and bring about improvement and learning.

The provider and registered manager neglected the environment people lived in placing them at risk of abuse.

People were not protected from the risk of the spread of infection. Many parts of the service and equipment in use were unclean. The clinical waste bin stored outside the building was not secured posing a risk to the public. Items of used personal protective equipment was disposed of in the rear garden. The laundry was extremely dirty and laundering facilities were inadequate. Soil pipes at the rear of the building were missing resulting in waste from bathrooms being flushed onto a pavement.

Assessments were not carried out on staff to make sure they were competent to safely manage people's medicines. The last medication audit was incomplete and previous audits could not be located; therefore, we could not be assured people's medicines were safely managed. There were concerns in relation to the management of people's medicines including the administration, recording and the use of 'as required' (PRN) medicines.

People and others were placed at serious risk of harm because the provider and registered manager lacked oversight and scrutiny of the service. They failed to operate an effective system and take responsibility for assessing, monitoring and improving the quality and safety of the service and for mitigating the serious risks found during this inspection.

Recent checks carried out on the environment were ineffective, they failed to identify any of the serious concerns we found, despite many of them being visible and longstanding.

There were sufficient staff on duty to provide care and support to people and safe recruitment process were followed.

The Care Quality Commission (CQC) took action to address the serious concerns found on the first day of inspection. The provider was invited to complete and send an urgent action plan, setting out how they were addressing the concerns identified during our inspection, and how they intend to address other serious concerns identified by inspectors immediately. We received an action plan from the provider within the agreed timescale, however it failed to adequately mitigate the risks.

During the first day of inspection CQC shared the concerns with the relevant local authority due to the significant risks identified by inspectors. The local authority took immediate steps to remove all 22 people from the service on the first day of inspection.

CQC used their urgent powers to ensure that people remained safe from potential harm.

Rating at last inspection
The last rating for this service was good (published 4 January 2021).

At this inspection we found breaches of regulation 12 (Safe care and treatment) and regulation 17 (Good governance).

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

Why we inspected
CQC received information of concern about people's safety. As a result, we undertook a focused inspection to review the key questions of safe and well-led only. Please see full details in the individual sections of this full report.

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 assurances that the service can respond to COVID-19 and other infection outbreaks effectively.

Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

The overall rating for the service has changed from good to inadequate. This is based on the findings at this inspection.

Enforcement
We have identified serious breaches in relation to risk management, preventing and controlling infection and the governance and leadership of the service.

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.

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 return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or varying the conditions of the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Riverslie

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. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

As part of this inspection we also 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 first day of the inspection was completed by two inspectors and the second day was completed by an inspector and an inspection manager.

Service and service type
Riverslie is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

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

Notice of inspection
Both days of the inspection were unannounced.

What we did before inspection

We reviewed information we had received about the service since it was newly registered. 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. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We checked the inside and outside of the premises, equipment and infection prevention and control measures. We spoke with the manager, two nurses, the cook and three care staff.

We reviewed a range of records. This included health and safety and cleaning records, recruitment records for three staff, maintenance records and a variety of records relating to the governance of the service. We also reviewed the management of medicines.

We also reviewed information provided by other health and social care professionals who we worked in partnership with during the inspection.

After the inspection
CQC used their urgent powers to ensure that people remained safe from potential harm.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question deteriorated to inadequate. This meant people were not safe and protected from avoidable harm.

Assessing risk, safety monitoring and management; Systems and processes to safeguard people from the risk of abuse

- People were exposed to extreme risk because their safety was not assessed, monitored or managed. We found serious concerns with the safety of both the inside and outside of the premises, utilities and equipment.
- There was a strong smell of gas on the ground floor and in the basement. Staff reported to us they had smelt gas over a period of six weeks and had reported this to the registered manager. We were told the gas system had been checked and deemed as safe, however documentary evidence of when the check took place and the findings could not be located. We raised our concerns with the manager and insisted they call a gas engineer to check the safety of the gas system. A gas engineer visited the premises during our inspection and identified a gas leak from two different sources. The gas engineer immediately turned off the gas supply to the premises and issued an important gas safety notice which stated the installation had been categorised as immediate danger and labelled it 'Danger do not use.' The disconnection of the gas meant there was no access to hot water to enable staff to attend to people's personal care needs, no facility for staff to safely wash their hands and no means for preparing hot meals for people.
- There were no window restrictors fitted to three bedrooms and two bathrooms on the upper floors and other windows in people's bedrooms were stuck shut with paint, providing no opportunity for ventilation within those rooms.
- There were mould and damp patches throughout the premises including in people's bedrooms, bathrooms and the laundry.
- The laundry room which was in the basement presented many hazards. There was a build-up of lint from the dryer on walls, surfaces and equipment in the laundry room, presenting a fire hazard. There were two open electrical boxes above the washing machine which had exposed live wires and a build-up of lint. The switches to a rotary ironer being used in the laundry were faulty and were stuck down with sellotape and string.
- The garden area presented multiple health and safety hazards to both people and staff. Paving throughout the garden was uneven and the boarders were overgrown with large weeds presenting a trip hazard. There were two unlocked sheds which contained hazardous items and substances. There were many hazardous items 'tipped' in the garden area including, rubble, large sheets of glass, discarded equipment including commodes, fridges and a stained bed mattress.
- The provider was issued with a fire enforcement notice on 4 July 2022 following an inspection of the premises by Merseyside Fire and Rescue Service on the 27 June 2022. The notice detailed fire safety concerns in relation to nine items.
- Storerooms in the basement close to the laundry and boiler room contained combustible materials including bed linen, clothes and cleaning products. This was despite the fire authority highlighting this as a

concern which needed urgent action in a fire enforcement notice dated 4 July 2022 following a recent inspection they carried out at the service.
● The provider did not operate robust procedures and processes that made sure people were protected from the risk of abuse. They neglected the environment placing people at risk of harm.

Preventing and controlling infection
● People were not protected from the risk of the spread of infection.
● Many parts of the service and equipment were unclean and unhygienic. There was a build-up of dirt and dust evident throughout the premises including behind radiators, on skirting boards, door thresholds and in people's bedrooms. A trolley used at mealtimes was rusty and the corners were encrusted with a build-up of food debris. The stair and landing carpets were heavily stained and furniture and mobility equipment such as stand aids, crash mats and wheelchairs were unclean. Many items of furniture in people's bedrooms including beds and chairs were unclean and in poor condition.
● The laundry room was extremely dirty, and the laundry facilities were inadequate. There was just one domestic washing machine which did not meet the standards for cleaning heavily soiled items. The washing machine only had the capacity of reaching a maximum temperature of 60 degrees when the recommended temperature for safe and effective laundering of heavily soiled items is 90 degrees.
● There were missing sections of soil pipes around the outside of the premises. One lead to two bathrooms. Waste from both bathrooms were flushed directly onto the pavement outside causing a build-up of waste and a foul smell. Another soil pipe at the rear of the building near to the kitchen had a gap in it where a connecting pipe has previously been, this provided access to the sewers for vermin.
● The yellow clinical waste wheelie bin which was stored on the car park at the front of the building, an area accessible to the public was full and the lid ajar. There were no facilities on the bin to secure the lid or to fix it to the wall. Used personal protective equipment (PPE) including disposable gloves were disposed of in domestic bins in people's bedrooms and in the garden area.
● On the first day of inspection an audit was carried out by an NHS Infection Prevention Control Nurse. We received the outcome of the audit on the second day of inspection. The service scored 30% out of a possible 100% which represented non-compliance with infection prevention and control.

Using medicines safely
● The management of medicines did not ensure people's safety.
● Staff who administer medicines had not had their competencies and practice assessed to make sure they had the required skills and knowledge to safely manage people's medicines.
● The last medication audit was carried out in June 2022; however, it was incomplete, and no previous audits could be located. A medication audit helps to identify potential and actual medication errors at different stages and ensures the policies, care plans, medication management and other relevant documentation is in line with how policy states they should operate.
● On the first day of inspection an NHS medication management team carried out reviews of people's medication. Their findings highlighted multiple concerns in relation to the management of people's medicines including the administration, recording and the use of 'as required' (PRN) medicines.

Learning lessons when things go wrong
● Lessons were not learnt when things went wrong.
● The provider and registered manager failed to assess and monitor the safety and failed to act when things were going wrong.
● On the second day of inspection the registered manager provided us with little evidence of improvements made to the service following our findings on the first day of inspection.

The provider failed to assess, monitor and mitigate the risks relating to the health safety and welfare of service users. This is breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

CQC took immediate action on the first day of inspection to ensure people's safety. We shared our concerns with the relevant local authority and used our urgent powers to ensure that people remained safe from potential harm.

Staffing and recruitment

- There were sufficient numbers of staff on duty to attend to people's needs.
- Staff were recruited safely. Checks were carried out on applicants to make sure they were suitable and fit for the job. All applicants were required to complete a check with the disclosure and Barring Service (DBS). DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Inadequate

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 the last inspection this key question was rated as good. At this inspection this key question has deteriorated to Inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- The registered manager and provider demonstrated a lack of understanding about their roles and responsibilities for ensuring the delivery of high-quality care. They showed a lack of understanding in relation to the management of risk and regulatory requirements.
- The provider and registered manager lacked robust oversight and scrutiny of the service. They failed to take responsibility for assessing, monitoring and improving the quality of the service and for mitigating risk.
- The registered manager had been promoted to a new role as operations manager, however they were still registered with the Care Quality Commission as the registered manager of the service. This meant they and the provider were legally responsible for how the service was run and for the quality and safety of the care provided.
- A new manager took up post in May 2022. The new manager told us they were not inducted into their role and the registered manager had offered them little support. The manager told us the registered manager had visited the service a total of five times since they took up the post of manager and they had not met or spoken with the provider. They told us "All contact is through [registered manager]."
- Audits and checks to monitor the quality and safety of the service were ineffective, including checks on the environment and medicine management.
- The registered manager carried out a visit to the service on 15 July 2022 and a further visit on 19 July 2022, just two days prior to our inspection. During their visit on 19 July the registered manager completed a monthly home review. During both visits the registered manager failed to identify any of the serious concerns we found, despite many of them being visible and longstanding. For example, the environment, including the laundry were both looked at as part of the review on 19 July 2022 and were passed as being safe, clean and tidy.
- The manager told us they had recognised and reported their concerns about the environment to the registered manager and requested resources to make improvements, including hiring a skip to remove the rubbish and rubble from the premises. The manager told us they were refused any resources including money to hire a skip.
- The registered manager failed to act upon concerns which staff raised with them about the safety of the gas.

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

- People's safety and dignity was seriously compromised which led to them receiving poor outcomes.

● No action had been taken to improve the safety and condition of the environment people lived in. Bedrooms, bedroom furniture and communal areas including outside spaces were in a poor state of repair, exposing people to serious risk of harm and undermining their dignity.
● There was a culture of not acting upon concerns which placed people at risk of harm and abuse.

Working in partnership
● There was a failure to work in partnership with other health and social care professionals to make sure people received safe and effective care and support.
● Reports following reviews carried out by other health and social care professionals during our inspection highlighted concerns about a lack of partnership working with others including; Occupational therapist, GPs and dieticians. For example, dieticians recommended nutritional supplements for three people due to them experiencing weight loss, however the three people did not receive the supplements as staff failed to follow the dietician's advice. A letter was sent to Riverslie from a GP requesting an appointment be made for another person to discuss concerns regarding their medication. This appointment did not take place as staff failed to act upon the request made by the GP.

The provider failed to operate effective systems to ensure the safety and quality of the service. This placed people at risk of harm. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 acted on their duty of candour. They notified CQC about events which they were required to do so by law.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● Questionnaires were used as a way of engaging and involving family members. Three questionnaires were returned completed in January 2022 and the results were mostly positive.
● Staff meetings were held to share information and updates about the service. Other topics discussed included; training, health and safety and 'resident' care.

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	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	The provider failed to assess, monitor and mitigate the risks relating to the health safety and welfare of service users. This is breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

NoP to cancel provider and manager.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	The provider failed to assess, monitor and mitigate the risks relating to the health safety and welfare of service users.

The enforcement action we took:

NoP to cancel provider and manager.