Ribble View Health Care Limited

Ribble View

Inspection report

39 Church Avenue
Preston
PR1 4UD

Tel: 01772346000

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15 May 2023

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Ratings

Overall rating for this service	Inspected but not rated

Is the service safe?	**Inspected but not rated**

Summary of findings

Overall summary

About the service
Ribble View is a nursing home providing accommodation and personal care for up to 30 people. The service provides nursing care to adults with multiple complex health needs and physical disabilities. At the time of our inspection there were 26 people using the service. The accommodation is provided over 3 floors, each floor has a dining room and communal spaces.

People's experience of using this service and what we found
This was a targeted inspection that considered how choking risks to people were assessed and their safety monitored and managed, so they are supported to stay safe. We also checked if people's freedom was being respected and were lessons learned and improvements made when things go wrong.

Based on our inspection of these aspects of safe care we saw records with clear risk management strategies in place and staff were fully aware of people's risks and how to manage them. Some processes and systems of communications used in the home could be improved to ensure more effective sharing of information.

There was a balancing of people's choices and the management of risk taking. Details in some records could be clearer but did not affect the care and management of choking risks. Staff were very knowledgeable about people's individual clinical presentations and how to manage them. The registered manager told us they were aware from recent learning that more communication with external professionals would be beneficial.

We have made a recommendation about enhancing the detailing in records to ensure absolute clarity and to promote more dialogue in communications both in the home and with external professionals.

Where accidents and incidents had occurred, actions had been taken to prevent them from reoccurring. There were systems and processes used in the home and by the registered manager and provider to ensure lessons learned were shared.

People were supported to have maximum 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. Staff were very knowledgeable about people's rights to make their own choices including those that may be considered unwise.

We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right support, right care, right culture is the statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and/or autistic people. We considered this guidance as there were people using the service who have a learning disability and or who are autistic.

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

Rating at last inspection
The last rating for this service was good (published 2 September 2022).

Why we inspected
The inspection was prompted in part by notification of an incident following which a person using the service died. This incident is subject to further investigation by CQC as to whether any regulatory action should be taken. As a result, this inspection did not examine the circumstances of the incident. However, the information shared with CQC about the incident indicated potential concerns about the management of risk of choking. This inspection examined those risks.

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

Recommendations
We have made a recommendation about enhancing the detailing in records to ensure absolute clarity and to promote more dialogue in communications both in the home and with external professionals.

Follow up
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?

Inspected but not rated

At our last inspection we rated this key question good

We have not reviewed the rating as we have not looked at all of the key question at this inspection.

Ribble View

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.

Inspection team
The inspection was carried out by 2 inspectors.

Service and service type
Ribble View 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. Ribble View 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.

What we did before the inspection
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 information gathered as part of our monitoring activity to help

plan the inspection and inform our judgements. We used all this information to plan our inspection.

During the inspection
We spoke with 5 people who used the service and 10 members of staff including 2 agency nurses who work regularly in the home, 3 senior carers, an activity coordinator, the chef and 4 care workers. We also spoke with the registered manager, deputy manager / clinical lead and the provider's regional operations manager.

We reviewed a range of records. These included 4 people's care records relating to risks. A range of records relating to the management of the service, including staff training and lessons learned from accident and incident records.

Inspected but not rated

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 this key question was rated good. We have not changed the rating as we have not looked at all of the safe key question at this inspection.

The purpose of this inspection was to check a concern we had about the management of choking risks. We will assess the whole key question at the next comprehensive inspection of the service.

Assessing risk, safety monitoring and management
● Risk and safety monitoring was well managed. Some processes and systems used for communications in the home could be improved to include more details. For example, the documentation used for shift handovers could contain more details.

We recommend the provider reviews the detailing in records to ensure absolute clarity and promote more dialogue in communications systems and processes used both in the home and with external professionals.

● The provider had system and processes in place to enable staff to identify and manage the risks of choking.
● People, where relevant, had been included in developing their own risk assessments.
● Staff understood the individual risks and needs of people and responded to them in a person-centred way.

Learning lessons when things go wrong
● Lessons were learned when thing went wrong. The provider had systems in place to learn from incidents to improve the safety of the service. This included sharing learning with the staff team as appropriate. Staff meetings and provider reports were used to ensure learning was shared.
● Staff were really clear about reporting concerns and about escalating concerns to the management.
● Staff told us they were confident in giving their opinion and how the whole team was open to discussing better ways of doing things.
● The registered manager told us they were aware from recent learning that more communication with external professionals needed to happen.

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)

- 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.
- Staff respected people's choices and balanced them with the management of risk taking.