Riverside Care Home Limited

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Inspection report

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Date of inspection visit:
03 February 2017

Date of publication:
01 March 2017

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 3 February 2017 and was unannounced. Riverside Care Home provides residential and nursing care for up to 42 older people, some of whom may be living with dementia. There were 38 people resident at the time of our inspection. This was the first inspection of this service.

The manager had submitted an application to us and this was in the process of being reviewed so they could become the registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Medicine management systems were not always safe. Information about medicines was not always available to ensure people received their medicines. Medication records were not completed to ensure checks could be made that people had received their prescribed medicines.

The provider had reviewed the staffing levels provided. We saw there were sufficient staff working although at certain times of the day, especially at lunch time, the way staff were deployed meant that staff were busy and were not always able to meet people's needs in a timely manner.

The care records did not always have the information needed for staff to provide effective care for people. Staff had not received all the necessary training they needed to support people. New staff were not provided with an opportunity to gain experience and get to know people before working as a member of the staff team.

Staff sought people's consent before they provided care and support. However, where some people may lack capacity, assessments had not always been completed to ensure decisions were only made by others when they lacked capacity to make decisions themselves. Applications to authorise restrictions to keep people safe were not always appropriate where people had capacity.

Quality assurance systems were in place, however these were not always effective as they had not identified concerns with medicine management, how decisions were made, how staffing was deployed and how people agreed and developed their support plans.

People were able to comment about the quality of the service. However, where concerns had been identified with gaining entry to the home, this had not always been resolved to people's satisfaction.

Staff had a good understanding and knowledge of safeguarding people and understood what constituted abuse or poor practice. Where harm or abuse was suspected, the staff knew how to respond to protect people.

Where people needed to have their food and drink monitored, systems were in place to ensure health support was sought promptly. Staff liaised with people's GP's and other healthcare professionals to meet people's changing needs.

People had opportunities to take part in a variety of activities and could choose if they wanted to be involved. People had developed good relationships with staff and were treated with kindness, compassion and respect. People maintained relationships with their families and friends.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

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.

Medication management practices did not always ensure that people received their medicines safely. Staffing numbers were not based around the dependency needs of people and the staff were not always deployed to ensure they met people's support needs in an effective way. People were protected against the risk of abuse because staff were able to recognise abuse or harm and took appropriate action when it was suspected. Staff were suitably recruited to ensure they were safe to work with people.

Is the service effective?

Requires Improvement

The service was not always effective.

Where people did not have capacity, it was not always evident how all decisions had been made in their best interests. Staff did not always receive the training they needed to support people effectively or have an opportunity to get to know their role before working as a member of the team. Staff understood the importance of gaining consent from people prior to providing care. People were able to choose what they wanted to eat and drink and had access to health care professionals to maintain their health and wellbeing.

Is the service caring?

Good

The service was caring.

Staff provided support to people in a kind and dignified way. Staff were patient when they interacted with people and their wishes and privacy were respected.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Information to ensure people received personalised care and support was not always available or reviewed. People knew how to raise concerns and complaints although they were not always confident these would be resolved to their satisfaction. A range of activities were arranged based on people's interests both in and out of the home.

Is the service well-led?

Requires Improvement

The service was not always well led.

Effective systems were not in place to assess and monitor the quality of the service. People were able to comment on the quality of service provision. The staff felt supported and valued by the manager.

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Detailed findings

Background to this inspection

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

This inspection took place on 3 February 2017 and was unannounced. Our inspection team consisted of one inspector.

We spoke with nine people who used the service, five relatives and visitors, four members of care staff, two members of the nursing team and the manager. We observed care in the communal areas of the home so that we could understand people's experience of living in the home. We also consulted with commissioners of the service. We did this to gain people's views about the care and to check that standards of care were being met.

The provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. As part of our planning we reviewed the information in the PIR. We reviewed information we held about the service. This included statutory notifications the registered manager had sent us and information received from people that used the service. A statutory notification is information about important events which the provider is required to send to us by law.

We looked at five care records to see if the records were accurate and up to date. We also looked at records relating to the management of the service including quality checks.

Requires Improvement

Is the service safe?

Our findings

People's medicines were not always managed or stored safely. We observed a medicines administration round and on two occasions we saw the medicine trolley was left unlocked and in an area which was unsupervised. We raised this with the manager who took action to ensure the trolley was secured to prevent people accessing the medicines. Medicines were not always recorded safely. Where there were hand written entries, only one member of staff had recorded this and checks had not been made to ensure the information was accurate. We checked the number of medicines that were stored in the home. We found that where medicines had been prescribed in boxes and foil strips, it was not possible to determine whether people had received their medicines as prescribed as an accurate record of the number of medicines received into the home had not been maintained. One person needed an 'as required' medicine for a stomach complaint. We saw there was no information available to support staff to determine when they needed this. One member of nursing staff told us, "I would ask the care staff how the person was feeling and whether they needed the medicine as sometimes they tell us they want it but they don't need it." There was no information available to demonstrate the person no longer had capacity to determine whether they needed this medicine and what was in their best interests. An audit had been carried out by the dispensing pharmacy had also identified these issues and improvements had not been made.

This meant there was a breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) 2014.

There were mixed views about whether there were suitable numbers of staff to support people living in the home. One person told us, "There seems to be a lot of staff around and they are there when I need them." Another person told us, "It's not very good at meal times or first thing in the morning. The staff seem very busy and we have to wait." We saw that staff responded promptly when people rang for assistance and people received individual support from staff. However at meal times, we saw food was served late and staff were not available as they were supporting people in their bedroom. One person told us, "The staff tell us its lunch time and we sit at the table for ages. I'm not happy with that." Another person told us, "We used to get our dinner at 12:30pm but now it's around 1:15pm and the pudding is even later." We saw on the first floor people sat in the dining area waited 45 minutes for their meal, even though the trolley of hot food had been delivered. The provider had not ensured there was a suitable mix of experienced staff deployed to support people. When new staff started working in the service, they were included in the numbers of staff on duty and were not given an opportunity to shadow experienced members of staff. One member of staff told us, "This has an impact on what we can do because if we are supporting new staff and showing them what to do, then it takes us longer and as they can't work alone; this reduces the support people can receive." The staffing tool used to calculate how many staff should be working in the service had not considered people's actual dependency and focused on how their service was funded; whether this was nursing or residential care. This meant how staffing was calculated and managed may not always be effective and had not considered how staff were deployed and their experience.

People felt safe and knew who to speak with if they felt concerned for themselves or others. Staff had received training and information to help them identify how abuse could occur and were knowledgeable on how to report any concerns One member of staff told us, "We had training on how to act if we were worried

about anything and we know how to make any report. It was made very clear that we must speak up about anything we see."

Consideration had been given to how people could move around the home and hand rails were in place along all the corridors, which were wide and enabled people to pass safely. We saw people being assisted to move around the home with their walking aids and staff spoke reassuringly and kindly to people as they supported them. Plans were in place to respond to emergencies, such as personal emergency evacuation plans. The plans provided information about the level of support a person would need in the event of fire or any other incident that required the home to be evacuated.

Recruitment and selection processes were in place to ensure that new staff were suitable to provide support for people who used the service. Checks had been undertaken before staff had started work and included police checks and written references. One member of staff told us, "I came here for an interview and was told what checks would need to be carried out. I filled in all the forms but had to wait until everything came back and was okay before I could start working here."

Requires Improvement

Is the service effective?

Our findings

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 Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the provider was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We saw that where it had been identified that people may lack capacity, assessments had not always been completed. For example, decisions had been made by others in relation to whether people wanted to be resuscitated without assessing their capacity. One member of staff showed us that they had started completing capacity assessments for some people and told us, "We know that we must do this but we have had a lot of people move here recently. We need to look at this so we make sure we only make decisions where people lack capacity."

We saw applications had been made to deprive people of their liberty although capacity assessments had not been completed to identify if they could make these decisions about their safety. One member of staff told us, "We wanted to make sure everyone was safe. As they are staying in the home, it was decided that a DoLS application was made for everyone." This showed that although the staff had received training for MCA and DoLS, they had not understood how to implement this. A deprivation of liberty can only occur where someone lacks capacity and therefore this needs to be assessed prior to any application and does not apply where people have capacity.

This meant there was a breach of Regulation 11 of the Health and Social Care Act (Regulated Activities) 2014.

Staff had not received all the training necessary to support people effectively. When new staff started working in the service we saw they worked alongside an experienced member of staff but were expected to work as part of the team and not given an opportunity to shadow as an extra member of staff. A member of staff told us, "We work as part of the team straight away and although we aren't left alone, we have to pick things up as we go." We spoke with the registered manager who agreed new staff had not been given an opportunity to learn about their role and receive support during an induction before working as part of the team.

New staff completed an induction; however some staff had not received training to support people to move safely. We saw one person was supported to move from their wheelchair. The person was supported to stand but had difficulty turning so they could sit in a comfortable chair. There was a risk assessment in place which recorded equipment should be used to keep the person safe but this was not used. We saw and records confirmed that not all staff had received training for safe moving and handling. One member of staff

told us, "I've done the training before where I used to work." Where staff had completed training with a previous employer, the manager told us they had not carried out checks to confirm staff were competent to support people to move safely. This meant staff had not been provided with all the training necessary to effectively support people.

This meant there was a breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) 2014.

People were provided with a varied diet and there was a choice of food and drink. At breakfast time, we saw people were offered crumpets or toast and drinks were served in cups and saucers. People were able to have breakfast when they chose and drinks were available throughout the day. Some people were supported to have nutrition through a tube fitted into their stomach because they had a condition which it made it hard to swallow food or have enough fluids. Plans were in place to ensure people were supported to have sufficient nutrition and fluids through the tube Staff could describe how people were supported and knew what to do to keep them well. People were weighed where there were concerns and we saw people had nutritional supplements prescribed. One member of staff told us, "We have a choice of flavours for people if they need a supplement and record what they have so it can be reviewed whether they have enough or need less."

People were supported to access health care services including their GP, occupational therapist and chiropodists. People told us they also received nursing care from nursing staff within the home to meet their needs. One person told us, "The staff are very attentive. When I've been unwell, they got the doctor to come and see me." Where staff had any concerns we saw that they sought advice and support for people from health care professionals. Outcomes of these visits were recorded and reflected within the care records so that all staff had clear information on how to meet people's health care needs.

Good

Is the service caring?

Our findings

People were supported with kindness and compassion and their smiles and laughter showed they were comfortable with staff We heard one member of staff notice that a person's hands were rough. They said, "Let me go and get some hand cream for you." We saw them massage this into the person's hands and spoke with them throughout asking, "Is that better?" Where people needed support to eat, we saw staff spoke kindly and encouraged people to try to eat their meal giving them to time to eat at a pace to suit them.

People were able to make daily decisions about their own care and chose how to spend their time and what time to get up. One person told us, "I don't like getting up in the morning. The staff know this and I often get my breakfast when people are having lunch, but that's fine with them." Another person told us, "I don't like to be disturbed at night so I've asked the staff to leave my door locked so I'm not disturbed and they respect this."

People liked the staff and the staff were knowledgeable about the people they supported. They spoke positively about people, describing their interests, likes, dislikes and their personal histories. Some people had limited communication skills and we saw that staff included them in any conversations that were taking place to ensure they were involved. The relationships between people and the staff were friendly and relaxed. One person told us, "I'm very fond of the staff, they are always very caring and have always got a kind word for me." Staff engaged with people and conversations were inclusive.

People's independence was promoted. One person said, "I was worried about moving away from my home, but I knew to be safe I couldn't stay there. It's nice here and they don't take over. I wouldn't like that. I like it here because I can still do what I can for myself." Another person told us, "I have a nice room and my own bathroom. I can manage by myself and the staff respect that but if I need them I can call for them. I think they have the balance just right." We saw that people's mobility aids were kept close to them so they could move around the home independently if they chose to do so. Some people were cared for in bed. Staff were observed knocking on their door gently before going in to assist them. People told us that when staff helped them with their personal care they always made sure their privacy and dignity was upheld.

People were supported to stay in touch with family and friends as they were able to visit whenever they wanted. One relative told us, "The staff are always friendly and we are offered a drink and made to feel welcome. We chose to come here because of how it felt when you came in through the door. We haven't been disappointed."

Requires Improvement

Is the service responsive?

Our findings

People had their needs assessed before they moved to the home. Information had been sought from the person, their relatives and other professionals involved in their care in order to determine how people wanted to be supported. However, we saw that for some people this information had not been used to develop an agreed plan of care. For one person, staff explained that this was because they were receiving respite care, although they had been residing in the home for several months. We saw information about how they needed support with moving in the home had not been updated and did not reflect the support staff provided. Another person needed support to change their position to prevent damage to their skin. We saw the staff had not liaised with health professionals to determine how frequently their position should be changed. One member of staff told us, "We have to help them to move every two hours." Another member of staff told us, "I'm not sure but we are doing this a minimum of every four hours." This meant people's care was not personalised and did not meet their individual needs.

This meant there was a breach of Regulation 9 of the Health and Social Care Act (Regulated Activities) 2014.

We saw that where concerns and complaints had been raised they were recorded. We spoke with people and their relatives and asked if they had any concerns. Without exception, they told us they were unhappy with how promptly the front door was answered. One relative told us, "You can be standing outside for ages waiting to get back in here. It's not too bad if I'm on my own but if we have been out it's not fair that [Person who used the service] has to wait in the cold." Another relative told us, "I've been let in by workmen and a doctor so it's not really about the security." This had been discussed within a meeting held for people who used the service, but people told us no improvements had been made. We had experienced this upon our arrival and we fed the comments back to the manager who agreed to review the current arrangements.

People were supported to be involved with social events and activities that interested them. One person told us, "I like a challenge and I like walking. I often go out for a walk and we're in a nice area by the park." Another person told us, "The activity staff are very good here. They are very organised. They recently put on a dance demonstration and I jumped at the chance to join in. We're having another one and I've been practicing the steps so I can learn the new dance. I really enjoyed it." There were photographs displayed of events that people had been involved with and one person told us, "It's good that I can still do what I like. If there's something I want to do, they do their best to arrange it."

We saw people were involved with quiz games in the afternoon. People joined different groups and challenged each other to complete phrases and answer questions. One person told us, "I like to do the games as it gets me thinking. We have a laugh too."

People had the opportunity to be involved with individual activities. One member of staff told us, "We often do hand massages for people or we sit and read the newspaper and talk about what's going on. We have a 'tablet' and ask people where they have been on holiday. We search the internet for pictures of those places and talk about what they did there. People love this and are often amazed at some of the photos of places and the memories it brings back."

Requires Improvement

Is the service well-led?

Our findings

The provider carried out checks to monitor the quality and safety of the service, which included checks on personal support plans. However, these had not identified the concerns we found that medicines were not managed safely, people did not always have a support plan that protected them from potential harm and staff had not always received training to ensure they provided effective support and had resulted in breaches of the regulations. This meant not all systems ensured that the service was well led.

The manager had submitted an application to become the registered manager and we were reviewing their application, which included attending an interview to assess their fitness. The manager understood the responsibilities of registration and notified us of the important events as required by the Regulations. People commented that the new manager was willing to listen and had met with them to discuss the plans for the home and how they wanted them to be involved. One person told us, "The manager is very enthusiastic and wants to make this a good home. We had a meeting and they told us about how much they wanted to come and work here and how they want to get everything right for us." Another person told us, "I've been here since the home opened and a lot is changing and there are more people here now. You're going to get some teething problems but I'm hopeful that things are going in the right direction and I'm happy here."

Staff felt supported by the manager and the team of nurses and received supervision to evaluate their work. One member of staff told us, "We've had quite a lot of changes in the short time we have been open but I feel supported and can always ask if I'm unsure of anything. We're finding out feet together as we are all new here. It's nice to be part of that and we want to make this somewhere we can be proud of."

Staff had a good understanding of the provider's whistle blowing policy and were confident that they would be supported to raise any concerns about poor practice in the service. One member of staff told us, "If we have any problems or see anything we are worried about then we know we need to speak up. You can do this at any time or if it's something more general you can talk about it when you meet in supervision."

People and staff told us that that their feedback about the quality of care had been sought in the form of a satisfaction survey. Feedback from the last survey was displayed for people and we saw comments included, 'Nothing is too much trouble for staff if you want anything done.' 'Everyone is always helpful and understanding.' Where people had commented about improvements that were required, the manager had recorded what action had been taken. We saw the service had received compliment cards from people who had used the service. Comments included; 'I found the atmosphere, décor, staff and other residents very friendly. The nursing care was excellent.' and 'A beautiful home with excellent staff.'

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	Regulation 9 HSCA RA Regulations 2014 Person-centred care
Treatment of disease, disorder or injury	The care and treatment for people had not been designed with a view to achieving service user's preferences and ensuring their needs were met.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent
Treatment of disease, disorder or injury	Care and treatment was not provided with the consent of the relevant person.

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	Proper and safe management of medicines was not in place to ensure care and treatment was provided in a safe way. Staff providing care and treatment did not always have the skills and experience to do so safely.