Indigo Care Services Limited

Riverside Residential Home

Inspection report

Camborne Way
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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We inspected Riverside Residential Home on 12, 23 March and 5 April 2018. The first two days of the inspection was unannounced which meant the home did not know we were coming.

Riverside Residential Home is registered to provide accommodation and personal care for up to 50 people. The home comprises one building, containing two units. One unit is named Oakwell and is a designated unit specialising in providing dementia care and the other unit provides residential care. All bedrooms on the Oakwell unit are ensuite, there is a communal dining room/lounge and access to secure gardens. Some of the bedrooms on the residential unit are ensuite, there is a large communal dining room/lounge, shared bathrooms and toilets and kitchen.

Riverside is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

At the last inspection in May 2017 we rated the home as 'Requires Improvement' in four of the five key questions and overall and as 'good' in the key question of caring. We identified breaches of the regulations relating to staffing and fit and proper persons employed.

Following the last inspection, the registered provider submitted two action plans to show what they would do and by when to ensure improvements would be made. The purpose of this inspection was to see if improvements had been made and to review the quality of the service provided for people.

At the time of our inspection the home did not have a registered manager. The last registered manager had left in December 2017. 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. The home was currently being managed by an improvement team alongside an interim manager who had joined Riverside in February 2018.

There were insufficient staff levels during our inspection. Feedback from people, their relatives and staff regarding staffing levels was mainly negative. The numbers of staff on some shifts were not at the levels stated by the interim manager and improvement team.

Recruitment processes were adequate. Interview notes were missing from one recruitment file.
Medicines were managed and administered safely. This was an improvement from the last inspection. Staff had received training in safe administration of medicines and had their competency assessed to administer medicines.

Risks to people were not always well managed. Accidents and incidents were not always reported. Effective

systems were not in place to reduce the risk and spread of infection. Soap and/or hand gel was missing from 50% of toilets. There was an infection control outbreak between day two and three of inspection.

People were not always supported to ensure their nutritional and hydration needs were met. Activities and daily pastimes were limited and we found the activity co-ordinator was on occasions taken away from this role and asked to support the care team.

Records showed staff had access to training and supervision to carrying out their role effectively.

The principles of the Mental Capacity Act were applied. Although some care plans did not contain a full list of decision specific assessments. DoLs applications were made timely following the completion of some of the mental capacity assessments.

People and their relatives generally spoke positively about the staff who cared for them. Some people did not look well cared for. People were supported with their preferences.

We observed people's confidentiality, privacy and dignity was not always respected. Staff were reminded to refer to people using initials only in public areas. Staff did not always knock on people's doors and announce themselves prior to entering a person's bedroom on the residential unit.

We recommended people and their families are involved in the review of people's care plans.

Further work was required by the interim manager and improvement team to be compliant with the Accessible Information Standard.

People and their relatives told us they felt able to complain if they were dissatisfied with the service provided. Complaints were investigated and responded to.

We saw examples of were lessons were learnt when things went wrong.

Feedback from people who used the service, their relatives and staff regarding the interim home manager and improvement team was not always positive.

The programme to improve the quality of service was not always effective and robust as the registered provider did not have oversight of the service.

People, relatives and staff were asked for feedback but this process was not regular and embedded.

This is the second time the service has been rated Requires Improvement. We have also identified a continuing breach and new breaches of the Health and Social Care Act (HSCA) 2008 (Regulated Activities) Regulations 2014. You can see what action we have told the provider to take at the back of the full version of the report. Full information about CQCs regulatory response to the more serious concerns found during inspection is added to reports after any representations and appeals have been concluded.

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.

Staffing levels were not consistently found to meet the needs of people.

Effective systems were not in place to reduce the risk and spread of infection.

Medicines were safe and well managed.

Is the service effective?

Requires Improvement

The service was not always effective.

People's nutritional and hydration needs were not being met.

The principles of the Mental Capacity Act 2005 were applied. Although, some care plans did not contain a full list of decision specific assessments.

Staff were supported with training and supervision to provide effective care and treatment.

Is the service caring?

Requires Improvement

The service was not always caring.

Care plans did not always reflect involvement of the person or their family member.

People did not always look well cared for. Privacy and dignity was not always respected.

People were supported with their preferences and had a good relationship with the staff who cared for them.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People were not always supported to be engaged in activities.

There was a complaints procedure in place. Some people and their relatives were unsure who the manager was.

The service had a person-centred approach to end of life care.

Is the service well-led?

Inadequate

The service was not well-led.

Breaches in the regulations persisted from the previous inspection.

There was a poor culture of leadership in the home where most staff did not feel valued and supported.

Regular meetings were not held with people who lived at the home, relatives and staff.

The programme to assess, monitor and improve the quality of the service was not robust or always effective.

Riverside Residential Home

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 12, 23 March and 5 April 2018; the first and second days of our inspection were unannounced, whilst day three was announced. On day one, the inspection team consisted of two adult social care inspectors, a specialist advisor in medicines, two experts by experience with a background in care for older people and an inspection manager for part of the day. Day two of the inspection continued with three adult social care inspectors and on day three the inspection was completed by two adult social care inspectors.

We did not ask the provider to complete a Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

To prepare for the inspection we reviewed the information we held about the service and requested feedback from other stakeholders. These included Healthwatch Barnsley, the local authority safeguarding team, the local authority infection prevention and control team, and the Clinical Commissioning Group.

During this inspection we spoke with12 people who lived at the home and six of their relatives to obtain their views of the care provided. We spoke with 18 members of staff which included ten care workers, two domestic staff, the chef, the activity co-ordinator, the interim manager, the deputy manager, the head of improvement and improvement manager.

We spent time observing people receiving support from staff in communal areas in both units in order to help us understand the experience of people using the service.

We reviewed a range of records which included three people's care files. We also inspected three staff members' recruitment documents, four staff supervision and appraisal records, staff training records, 12

people's medicines administration records, accident and incident records, and various other documentation related to the running of the service.

On the first and second day of our inspection there were 29 people living in the home and on day three there were 28 people living at the home.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe at Riverside. Comments included, "I certainly feel safe here", "Without a doubt I feel safe here," "I just shout out if I want help" and "Staff come when they can, but they get very busy." We asked relatives whether they thought their family members were safe and we received a mixed response. Comments included, "I could turn to any of the staff here for help and support if I was worried about anything", "We are sure that [relative] is safe here. It's the shortage of staff that is a concern", "I cannot absolutely say this is a safe place," Sometimes there's not enough staff at weekends" and "I have known there be a shortage of staff. Sometimes that staff are rushed off their feet."

At the last inspection in May 2017 we rated this key question as requirements improvement. We identified two breaches of regulations relating to insufficient numbers of suitably quality, competent, skilled and experienced staff deployed in the service and fit and proper persons employed. Following the last inspection the registered provider sent us two action plans which identified how they were going to improve the service. At this inspection we still identified risks relating to insufficient numbers of persons deployed in the service. Sufficient improvement had been made relating to fit and proper persons employed which meant the provider was no longer in breach of this regulation.

On the first day of our inspection we saw the interim manager, deputy manager and improvement manager all had a visible presence in the home and were undertaking duties which would otherwise have been completed by care staff. For example, the deputy manager was serving drinks from the trolley and the interim manager was setting tables. One staff member said, "The manager's been out. We don't normally see them." Another staff member said, "On the other side, there's a lot of things that don't normally happen, like management helping out." A third staff member said, "They've had [interim manager], [deputy manager] and [improvement manager] (providing assistance). It wouldn't normally happen." A fourth staff member said, "Staffing is just atrocious. We do seem to have a lot of sickness. Most days we're pushed to our limits." A fifth staff member told us, "Things aren't getting done."

The interim manager told us a care staff member had called in sick and we noted another member of care staff left part way through the morning due to personal reasons. A staff member told us, "There's nothing in place for sick. We've got no back up anymore." A second staff member told us, "They (referring to the registered provider) rob Peter to pay Paul." A third member of staff said, "We don't' have any bank staff." We spoke with the interim manager who told us the service no longer had a list of bank staff to use at short notice and this was an area they were looking to recruit to. They further told us they had arranged for the activities co-ordinator to step into the role of care assistant.

In addition, we found the cook was on annual leave and the kitchen assistant was covering for their duties. A domestic member of staff was covering the role of kitchen assistant. These staffing changes meant there were no hot options on the breakfast menu with the exception of toast and one person who had porridge. We observed the medicine round finished after 11:00am which we were told had run late due to the person responsible for administering medicines having to help care staff to get people up and ready.

We saw people in the residential unit being offered hot drinks and snacks at 11.40am by the activity co-ordinator with lunch being delayed from the usual time of 12.30pm due to knock on effect from the late breakfast. At 1.45pm we saw people were still finishing their lunch with people on the residential unit still eating their main course. Staff told us tea was scheduled to be served at 4:30pm. This meant meal times were close together and people would not have had an opportunity to regain their appetite over such short spaces of time.

We observed a visiting healthcare professional could not carry out their scheduled appointment as the person concerned was still having breakfast and they had to return later in the day. This meant people may not be supported to receive timely holistic healthcare.

The registered provider used a dependency tool to calculate how many staff were required to meet people's care needs. The interim manager, deputy manager and staff we spoke to told us staffing levels for the day time were two seniors and five care workers and night staffing levels were two seniors and three care workers. We looked at the staffing rotas over a seven week period from February to March 2018. Out of 49 day shifts there were 27 days when the number of seniors and care workers on the rota did not match what we had been told, and of which 12 of these days had only one senior on the rota for the whole 12 hour shift. Out of 49 night shifts there were 30 nights when the staff rota did not match what we had been told and of which there were 20 nights when only one senior was on shift. This meant there were occasions where day and night shifts were not staffed as stated.

We concluded this was a continuing breach of regulation 18 (Staffing) (1) (Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed in order to meet the requirements) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at infection control and overall cleanliness in the building. Between days two and three of inspection there was an infection control outbreak. We saw a shower chair was dirty, a toilet seat raiser was rusted, two toilets had no bins and a toilet roll holder was broken. We looked in the communal bathroom rooms and toilets and found there was no soap and/or hand gel in 50% of these areas. We found both medicine rooms to be very dusty, the sluice was dirty and had no gloves or aprons. We looked at the cleaning schedules and saw the residential medicine room was last signed on 8 February. We spoke with the interim manager who assured us this would be rectified. On day three of inspection we saw these areas were clean. This meant people may be at risk of infection through cross contamination.
We concluded this was a breach of regulation 12 (2) (h) (Safe care and treatment) (assessing the risk of, and preventing, detecting and controlling the spread of infections, including those that are health care associated) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the recruitment process for three members of staff and found these contained an application form and references. We saw Disclosure and Barring Service (DBS) checks had been obtained. DBS checks return information from the Police national database about any cautions, convictions, warnings or reprimands and help employers make safer recruitment decisions to help prevent unsuitable people from working with vulnerable groups. In one recruitment record we saw a file note stated the first day interview notes had been sent to the registered provider's human resource department for filing but these had subsequently been mislaid. We saw the second day interview notes were also missing from the file. We spoke with the head of improvement who told us the person who carried out the first day interview no longer worked for the registered provider and human resources department had been unable to locate the either documents. This meant there was not a full recruitment record available for inspection purposes.

The service had a safeguarding policy in place and staff had received safeguarding training. One staff

member said, "I have had a whole range of safeguarding training." Staff we spoke with could describe signs of abuse and knew to report concerns to the interim manager to keep people safe. Certain accidents or incidents must be reported to the local authority and to the Care Quality Commission (CQC); the requirement to report safeguarding incidents was also stated in the home's own safeguarding policy and procedure. We found that an incident had occurred which should have been notified to both CQC and the local authority but had not been. This meant the local authority safeguarding team and CQC had not been informed of all incidents between people at the home and could not therefore take appropriate action.

We reviewed the records for accidents and incidents which had occurred at the home to see if lessons had been learned. We found each accident or incident had been recorded and there was evidence of oversight by a manager at the home. However, most records we viewed for 2018 had no record of action taken in response to the incident or any lessons learned. For example, four incidents in February 2018 involved altercations between people; however, the actions recorded to minimise a reoccurrence referenced care staff completing the wrong forms. Other incident forms concluded with plans to take action, for example, 'Staff to have training around dementia awareness', but did not state whether actions had been completed. We noted management oversight, including the recording of meaningful actions, had improved in March 2018. The interim manager explained the member of staff overseeing the accident and incident forms had received training at this time, so we could see this had been effective.

The interim manager told us accidents and incidents at the home were analysed at monthly clinical governance meetings and discussed in daily 'flash meetings'. The improvement manager said they did not wait until the end of the month to take action if a person needed a referral, for example, to the falls team or GP. This would be done as soon as the requirement was identified.

Records we reviewed also included detailed lessons learned investigations into a small fire at the home and an occasion when both washing machines broke down at the same time in 2017. The interim manager explained what had been done to minimise either occurrence happening again and records we inspected showed appropriate steps had been taken. The head of improvement gave an example of learning from an incident whereby a person in another of the provider's homes could not receive their medicines as they had run out. In response, the provider amended their medicines policy and we saw the 'handover' document, used to record and convey information from shift to shift had been improved. This meant the provider learned lessons when things went wrong, and had addressed the issues identified with accident and incident documentation.

Care plans we looked at showed people had risks assessed which included falls, nutrition and hydration and moving and handling. In one care plan we looked at we found there were two fall risk assessments. One falls' risk assessment dated 24 April 2017 stated the person was at 'high risk' of falls and a falls risk assessment monthly analysis dated 9 March 2018 stated the person was at 'very high risk' of falls. We looked at a night time evaluation plan dated 3 March 2018 and saw this stated '[Name] is checked two hourly throughout the night. [Person] does have in place 30 mins obs (minutes observations) which does wake [Name] up if we keep going in their bedroom'. This meant people could be at risk of not receiving the correct support as there was contradicting information within care plans.

People's confidential information was securely stored. We saw care plans were kept in a locked cabinet. This meant people's confidentiality was safe and maintained.

Throughout day one of inspection we observed safe moving and handling transfers as staff ensured people had consented to being assisted to move and they continued to talk to the person to provide guidance and reassurance as they safely completed the transfer. On day two of inspection we saw staff who were not on

shift attended the home to complete moving and handling training. We saw two members of staff assisting a person to go for lunch. The person was deeply asleep and although we observed staff speaking to the person to try to wake them up we saw staff applied the sling anyway and were just about to hoist the person when they eventually woke up. We noted the manoeuvre was done safely and the person was did not appear distressed. However, this demonstrated consent to be moved was not sought from the person and therefore their dignity was not respected.

We looked at the management of medicines and found this was safe. Most medicines were administered via a monitored dosage system (MDS) supplied direct from a pharmacy. A MDS is the method whereby medicines for a person for each time of day are dispensed by the pharmacist into individual trays in separate compartments. The home carried out separate medicine rounds per unit. We observed a member of staff administering medicines to people in the separate units. The administration of medicines on both units was seen to be safe. Staff prepared each person's medicines and knew how people liked to take their medicine. They spoke knowledgeably regarding individual preferences.

Staff who were responsible for the administration of medicines told us they had undergone additional training and had their competency assessed through an annual review. Training records evidenced staff had completed the administration of medication training.

Daily records were kept for the fridge and medication room temperatures. We saw temperatures recorded were always in range. Medicines were kept in locked cupboards in the clinical rooms which were locked when not in use. This meant medicines' were stored safely.

Some people were prescribed PRN, or 'as required' medicines, such as paracetamol. We found PRN protocols were in place to help ensure these medicines were appropriately administered and details recorded how to recognise when people may need PRN medicines.

Medicine administration records (MARs) were used to record the administration of medicines. We looked at a selection of MARs and saw these had been completed appropriately with no gaps in recording. We saw each MAR included a picture of the person, details of known allergies and how the person preferred to take their medicine. We saw staff members check the specific medicine against the MAR to verify the prescription and medicine instructions. They then signed the MAR to confirm once the person had taken their medicines. This meant potential errors in medicine administration were identified and could be rectified immediately.

Records showed a range of checks were in place to ensure the safety of the home's equipment, facilities and utilities. This included the supply of gas and electricity, and the safety of equipment used by staff to help people move. The home's fire safety equipment was checked regularly and staff took part in evacuation drills.

People had personal emergency evacuation plans (PEEPs) which could be used by emergency personnel in the event of a fire or other emergency to help people evacuate. We looked in one care plan and saw the PEEP had not been updated to reflect this person had recently changed bedrooms. We spoke to the interim manager who assured us this would be rectified immediately. We later saw the PEEP had been updated to reflect the change.

Risk assessments were in place for various aspects of the building and for tasks undertaken by staff. We saw actions from risk assessments for health and safety, fire safety, and Legionella had been compiled into one action plan by the registered provider's maintenance team, who were putting the required improvements in place. This meant the risk to people posed by most aspects of the building and utilities had been assessed

and managed.

Door guards to automatically close a door in an event of a fire were fitted to each bedroom door. During our inspection we noted a door stop was sounding continually which indicated the battery needed changing. A domestic member of staff confirmed this had been ringing for several days. Another member of staff told us it had taken three to four weeks to replace another battery in a door guard and the person who used that bedroom had stated they could not sleep with the sound of beeping. We spoke with the interim manager who told us this had been reported to maintenance and was due to be fixed on 3 April, but to due to an infection control outbreak the maintenance person could not visit the home. They further stated this was due to be fixed on 6 April. On day three of inspection, we observed the concern was discussed during the mid-morning flash meeting (for heads of department) and saw the deputy manager went to get a replacement battery and fitted this with some assistance from the head of improvement. This meant the premises were not maintained in a timely way which respected people's privacy.

Each unit had separate dining room/lounge communal areas with the Oakwell unit having access to an enclosed courtyard area. The courtyard area could be viewed from a number of windows in the home and was not kept tidy or presentable and had no shelter from the wind or rain. On the first day of inspection we saw one person who accessed the courtyard to have a cigarette had no choice but to sit in the rain for long periods whilst they smoked. The person told us it was their choice to go outside, but said they "Wished there was a kind of shelter." We brought this to the attention of the interim manager who confirmed a smoking shelter had been ordered on 13 March 2018. We observed wheelchair access to the courtyard area was impaired as the ramp in place to support wheelchairs kept slipping sideways when being used. We also saw people who wished to re-enter the building had to tap on the window to inform staff they needed assistance to come back into the building. This meant some people were unable to access the courtyard without assistance.

Requires Improvement

Is the service effective?

Our findings

People and their relatives told us staff had the skills and training they needed to provide effective care. One person told us, "They all look after me." A relative said, "The staff do a whole range of training and it's good to know that."

People were not always supported to eat and drink enough. In one care plan we looked at we saw the person needed hourly fluids day and night and their fluid intake was being monitored on a fluid balance chart. We inspected the person's fluid balance charts and saw these had not been completed on an hourly basis throughout each 24 hour period. The fluid balance chart for 9 March had nothing recorded at 19.00 hours, 10 March chart recorded 11 fluids offered between the times of 8.30am to 5.30pm, the undated chart recorded seven fluids offered between 8am to 4pm. At the time of inspection on 12 March we saw the fluid chart for 12 March had nothing recorded. The home also recorded people's daily food intake and fluid on another daily food and fluid record chart. We looked at this chart for 12 March and saw the person had been recorded as asleep for the early morning meal time and no fluid or food had been recorded on this separate form. We raised this with the interim manager who assured us the person had been offered fluids but agreed they were unable to evidence this as the fluid balance chart had not been completed.

Staff in the kitchen were providing desserts for people who had diabetes which was not tablet controlled. We spoke to the interim manager and cook who told us this was managed by ensuring those people with diabetes were served smaller portions for dessert. We checked this with two staff members who told us they were not aware of this practice and people received the same dessert portion sizes. We looked at kitchen records relating to people's dietary requirements and saw these were last updated in October 2017. The home had admitted people since this date. We noted several people were still on the list that had not lived at Riverside Residential Home for some time and one person who had moved into the home was not on the list at all. We spoke with the chef who was aware the list needed updating. This meant people may not receive food and nutrition in line with their dietary requirements.

We concluded people were not supported to maintain their food and hydration needs. This is a breach of Regulation 14 (1) and (2) (b) (meeting nutritional and hydration needs) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We observed the breakfast and lunch time meal in the dining rooms. Although menus were displayed in the communal rooms it was observed that the menus on display did not relate to the meal that was being served on the first day of inspection. The menu on day two of inspection was fish and chips, but was advertised as sausage casserole, honey roast ham and parsley sauce. On day three of inspection we saw food was provided as per the food advertised on the menu.

On day one of inspection we noted breakfast was served late and at 11.00am two people were still waiting for their breakfast. We saw people were offered different cereals and when they had eaten, staff routinely asked if people had eaten enough and whether they wanted more food and drinks. One person who was offered toast was asked by a staff member, "Would you like jam on it? Would you like marmalade on it?" This

meant people were given a choice of different toppings on their toast.

We asked people what they thought of the food they received. One person told us, "It's sandwiches every day for tea. As long as I've been here, it's been two sandwiches and a cake every day." Another person said food was sometimes served cold and a third person said, "It's alright, I suppose." A relative told us, "[Name is eating so much better then when they were at home." A staff member said, "I think they could be more creative with food."

We heard staff discussing the menus for the day with people and offered them the choice between the main menu or an alternative. There were no condiments on the dining tables and people were not offered these during the meal. We saw people were served food from dishes on a mobile heated station. Staff were seen to be calm and patient when delivering people their meals. Our observations showed staff ensured people were sat or positioned correctly and were comfortable to eat their meal. People were offered drinks throughout the meal time. The interim manager told us they had ordered new menu holders for the dining tables which would have pictorial menus.

Staff received an induction programme which included completing mandatory training before starting care work. New staff were required to shadow more experienced staff to build confidence and get to know the people they would be supporting. This demonstrated staff received training to help them develop the skills needed to deliver effective support and care.

Staff new to the organisation and to a care role were required to complete the Care Certificate. The Care Certificate is a standardised programme of knowledge designed to ensure staff have a good knowledge of all the essential standards for their daily caring role. Records we inspected confirmed two new members of staff were in the process of completing the Care Certificate. This demonstrated staff received training appropriate to help deliver effective support and care.

We looked at the staff training matrix and saw staff had completed training in accordance with the registered provider's mandatory training requirements. For example, customer service and dignity, dementia awareness, food safety, understanding and managing behaviours that challenge. A staff member told us, "A notice gets put up in the staff room if any training is due." This meant staff received appropriate training to enable them to carry out their roles effectively.

Records showed and care workers confirmed they received regular supervision and assessments of their competence. Supervision sessions were a mixture of one-to-one discussions with a manager, or group supervision sessions with colleagues, in accordance with the provider's policy. We asked staff whether they received supervisions and were given a mixed response. One staff member told us, "They're basically if we're doing anything wrong or if we've got any concerns." Another staff member said, "No, I don't think they are (useful). They take no notice to whatever you say." A third staff member said, "Group supervisions are essentially memos which are instructional and would not look at staff development." A fourth staff member told us, "They (referring to supervision) are alright."

Care workers also received an annual appraisal where they were graded for aspects such as team working, attitude and professionalism. Appraisals also required the care worker to reflect on their progress over the preceding year and consider goals. This meant care workers were supported in their roles in line with organisational policies.

We asked the interim manager how good practice was implemented at the home to improve the service. They gave us examples of good practice in dementia care which they were using to update table wear, such

as cutlery and crockery, to make it easier for people living with dementia to use. The interim manager also planned to improve signage at the home and update the activities provision and equipment for people living with dementia. We saw additional staff training on dementia had been booked. Records showed staff were also about to undergo 'React to Red' training. React to Red is a good practice campaign which focuses on the prevention of pressure ulcers. This meant good practice initiatives to drive improvement at the home were being planned. We will check that this has been progressed at the next inspection.

People were supported to access a range of healthcare professionals in order to maintain their holistic health. People's records evidenced they accessed to GPs, district nurses, dieticians and dentists. A relative told us, "They never hesitate to call the doctor if necessary and they always keep us informed." A healthcare professional told us they had no concerns regarding people's appearance and said the timeliness of referrals they received was appropriate.

The internal design and flow of the building was appropriate for some of the needs of the people who lived there. The Oakwell unit was decorated in a dementia friendly manner with an outdoor street theme and individually coloured bedroom doors which meant people were able to recognise their own room. Some people on the residential unit also lived with dementia. The residential unit was not decorated in a dementia friendly way, the walls and bedroom doors were all the same colour and the unit had narrow corridors but was well lit with pictures on the wall. In both units we saw people's bedrooms were personalised with pictures, ornaments and photographs of family members.

We checked to see if the service was compliant with the Mental Capacity Act 2005 (MCA). The 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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards or DoLS. We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

Staff training records showed staff received training in MCA and staff we spoke to could describe what the MCA meant. One staff member told us, "Just because somebody hasn't got mental capacity, it doesn't mean they can't have choice."

The care plans we looked at did contain some appropriate and person specific mental capacity assessments which would ensure the rights of people who lacked the mental capacity to make decisions were respected. However, we saw not all care plans we looked at contained a full list of decision specific assessments. For example, best interest decisions had been made for one person, but there were no mental capacity assessments in place for making choices in relation to eye care, foot care, mobility and falls needs.

We found the interim manager had a good knowledge of the MCA/DoLS process and could describe what decisions people may need to have their capacity assessed for, should there be any doubt about their mental capacity. The interim manager had also asked people's relatives to supply evidence they held Lasting Power of Attorney (LPA) for their family member, if they had it. LPA allows people's relatives to make certain decisions for them when they lose capacity to decide for themselves.

Requires Improvement

Is the service caring?

Our findings

Most people who used the service and their relatives spoke positively about the staff who helped care and support them. People told us, "They are good to me", "I am well looked after here" and "There is such kindness offered." However, one person said, "Nobody asks me if I'm happy."

Relatives comments included, "The staff show [Name] such patience and understanding", "We are always impressed how well the staff know [Name], [Name] is a challenge", "Most staff are friendly. The ones that have been here a long time" and "The thoughtfulness towards [Name] is second to none." However, another relative told us they did not feel their [relative] was receiving appropriate care and proactive support.

Staff did not always routinely knock on people's doors before entering. A relative said, "How can [Name] be handled with dignity when they [referring to the management of the service] get so much wrong." For example, in the residential unit we saw staff entering one person's room without knocking and announcing themselves on several occasions. However, in the Oakwell unit we observed staff knocking on doors and calling out before they entered a person's bedroom or toilet. This demonstrated people's privacy and dignity may not always be respected.

People were not always supported to maintain their independence. On day one of inspection we saw a person struggling to eat their food independently as their food had fallen on to themselves and the floor. A staff member told us the interim manager had instructed staff to remove the food plate guards which were previously used to support people eat their meals. They further said this was for dignity reasons. We saw staff question the removal of plate guards with the improvement manager who subsequently said staff could use the plate guards. On the third day of inspection we saw two people using a food plate guard.

People's confidentiality was not always respected. One day three of inspection we heard staff discussing private information regarding a person during a flash meeting taking place on a corridor which was a thoroughfare in the home. This was attended by the head of improvement, interim manager, deputy manager, senior carer, activities coordinator, administrator and the cook. We further heard the head of improvement ask the interim manager to refer to people using initials only as the meeting was not private.

People did not always look well cared for. We saw some people had not had their hair combed properly and had long and dirty fingernails. Some people had long facial hair that had not been removed. On the first day of inspection we asked a staff member whether people could have baths and showers when they wanted, they told us, "Baths will get massively missed today (referring to the delays and low staffing)." This meant people were not consistently supported to maintain their dignity in relation to their appearance

People were not always treated with dignity and respect. This was a breach of regulation 10 (1) (2) (a) (Dignity and respect); Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

People had a good relationship with the staff who cared for them. People told us staff were good at listening to them and meeting their needs. During our inspection we observed positive interactions between people

who used the service and staff. Staff demonstrated a genuine mutual respect with good humour and an understanding of specific communication needs. We observed one staff member engage with a person who had limited verbal communication skills working at eye level to wipe their hands before lunch. A staff member said "I always think, "Treat them how you would want your mother to be treated." However, another staff member told us, "I would not put my family in here."

The home used therapy dolls as part of the support they gave people who lived with a diagnosis of dementia. Evidence shows the use of a therapy doll can give people a renewed sense of purpose by having a doll to interact with and can improve a person's communication skills which can produce improvements in their communication with other people. In addition, some people with dementia find great enjoyment from holding or being with a doll. We observed one person benefiting from doll therapy and saw staff moved their doll around with respect.

People were supported with their religious and cultural needs and this was reflected in some of the care plans we looked at. One care plan detailed a person's religious needs and we saw the person was supported to maintain their religion. A member of staff told us, "They do come out and give [Name] a religious service in the home." Another care plan stated the importance of religion to the person and their family although the plan did not state what religion the person practiced.

Care plans we looked at were detailed and person centred. We saw a life history document that provided an easy and practical way of recording people's life history, preferences, their routines and likes / dislikes in the care plans we looked at. In one care plan we saw a person disliked to wear their glasses and did not want to attend religious services. This demonstrated people would be supported with their preferences.

Care plans we sampled did not always reflect the involvement of the person or their family members in their development. One relative we spoke with told us they were not kept up to date regarding their family member's care without having to ask and they were not always informed prior to decisions being made. For example, a decision was made to move their relative to a different bedroom due to a long standing maintenance issue that had not been resolved in the original bedroom and they were not informed prior to their relative being moved. We spoke to the interim manager who told us they were aware of the concern and was carrying out an investigation. This meant people and/or their relatives were not always involved in their care planning.

We recommend the interim manager involves people and their family members when reviewing people's care plans.

People had access to advocacy services, or were referred to them by staff at the home, if they needed help to make decisions. One person had an advocate who visited them regularly, whereas other people had relatives and friends who advocated for them. The interim manager had a good knowledge of advocacy services and could describe the referrals process. We saw details about advocacy services were displayed in the home. This meant people had access to support with independent decision-making if they needed it.

We observed visitors to the service were welcomed in a caring and friendly manner without restriction. We saw staff talk to visitors and routinely offer drinks. This demonstrated people were supported to maintain relationships with people who were important to them.

Requires Improvement

Is the service responsive?

Our findings

People and their relatives told us staff were responsive to people's needs. One person said, "I'm happy with what the staff do with me." Another person said, "The staff sort out my problems." A relative commented, "Some of the long standing staff know my relative well, but with all the staff changes, it's not the same now."

People and relatives told us there were not enough social activities arranged on a daily basis for people who lived at the home. The service had an activities co-ordinator in post and a programme of activities was on display in the home. One person told us, "Activities are naff." Another person said "Activities are very poor, [name of activities co-ordinator] does not do them. Once a fortnight a minibus takes people out, but they are the same people each time." A third person said "It's always quiet."

A relative told us, "I have seen less and less activities as the weeks have passed. They hardly do anything. People are bored." Another relative said, "My family bring our own board games in to play with [Name]. [Name] engages in all sorts of things, but nothing happens these days." A further relative said, "To be fair [Name] will not always join in the activities, but we've not seen a lot happening lately."

A staff member told us, "I don't think [name of activities co-ordinator] has got enough budget." Another staff member said, "It isn't right that the residents should be bored, they need occupying."

On our first day of inspection we saw the activity co-ordinator undertaking the role of care assistant throughout the day. We asked the activities co-ordinator what they had planned to do today and they told us, "I don't think I'll get round to doing any activities today. I am often asked to cover the care duties as we are always short staffed." Later in the day we noted the activity co-ordinator had been asked to pick some paperwork up from a hospital on behalf of the home. This meant people did not have access to activities.

On day two of our inspection we saw the activities co-ordinator using an iPad to show one person images relating to the person's interests and we observed an external person visited the home to carry out a physical activity with people.

We spoke with the activities co-ordinator who confirmed a minibus from a sister home was used by Riverside Residential Home once a fortnight to take residents out and said, "I do ask them where they'd like to go." They further told us they had taken residents to the heritage centre, a garden centre, the farm and Barnsley Town Hall Museum.

We looked at activity records for March 2018 and saw activities had been recorded as taking place on six days throughout March. There were no activity records available for January and February 2018. We saw activities had been recorded as taking place on ten days during December 2017.

People did not have access to a scheduled programme of activities. We concluded this was a breach of Regulation 9 (1) and (3) (b) (Person Centred Care) of the Health and Social care Act 2008 (Regulated

Activities) Regulations 2014.

People's care plans reflected their needs; these included a care needs summary, social history, mobility, nutrition and cognition although we noted some updating was required in the plans we looked at. In one care plan, the person had lost weight since admission and the service was monitoring their weight using a malnutrition universal scoring tool (MUST). The person consistently had a MUST score of 2 (high risk) and we could only see evidence the person had been weighed four times in the past six months. We spoke with the improvement manager who was aware weekly weights for people living at the home were not being carried out prior to improvement team taking over the running of the home. They further told us weekly weights had been restarted.

We asked care staff whether they routinely looked in the care plans to familiarise themselves with a person's requirements and support needs. A staff member said, "To actually go through them, no." Another staff member said, "I am expected to be fully involved in the reviewing of care, I simply don't have the time as everything is done in a rush." A third staff member told us they were asked to add to the care plans and the service would choose a resident of the day which meant the person was weighed and their room deep cleaned.

On the third day of inspection, a person was found on the floor in their room and an emergency alert was sounded by the staff member who found them. The response was effective as around eight staff attended, whilst there were still staff in communal areas to ensure people were supported. Another person was in bed and was not well.

All organisations that provide NHS or adult social care must follow the Accessible Information Standard (AIS). The aim of the AIS is to make sure people who have a disability, impairment or sensory loss receive information they can access and understand, and any communication support they need. This requires organisations to ask, record, flag and share information about people's communication needs and take steps to ensure people receive information which they can access and understand, and receive communication support if they need it. At the time of the inspection the interim manager was knowledgeable on the requirements of the standard. They further told us they had identified work was required throughout the home to meet the standard and AIS requirements was included in their action plan. We will check that this has been progressed at the next inspection.

People who used the service and relatives we spoke with told us if they had any concerns they would feel able to raise these, although some people and relatives were not aware who the manager was. A person and their relative told us, "We are not sure who the manager is, but would let anyone know if we were worried about anything." Another relative said, "The temporary manager (referring to the interim manager) is approachable, they must be fed up of us complaining." A further relative said, "We are sick and tired of providing new glasses. How can they go missing so easily."

We saw the complaints policy and information on how to complain on display in the reception area. We reviewed how the service recorded, investigated and responded to complaints. We saw four complaints had been received by the service since the last inspection in May 2017. Records showed each complaint had been investigated fully with either a response sent to the complainant or a meeting held with them to discuss findings. One serious complaint made in August 2017 had triggered a root cause analysis by the registered provider into the circumstances leading up a specific incident. We saw a full explanation letter and apology had been sent to the complainant. This meant complaints made about the service were investigated and responded to.

We spoke with the interim manager about end of life care provision at Riverside Residential Home. They told us the home used an end of life care plan supplied by community nurses who supported the home if people needed specific medicines as they neared the end of their lives. We looked at the training matrix and saw end of life care training was not routinely offered to all care staff. The interim manager told us they were exploring whether additional staff training was available from either community nurses or the local authority, with a view to appointing end of life care 'champions' amongst the care staff. They further told us, "It's making sure death when it comes is as dignified and pain-free as possible. We want it to be a positive experience for the family."

In a care plan we looked at we saw there was an assessment for last days of life care which included where you would like to be cared for, advanced plan, expressed wishes regarding after death care, medicines management plan, communication, symptoms management, priorities of care of the dying and a multi-disciplinary team evaluation. We saw useful advice for relatives and carers when someone has died. The meant people would receive the end of life support according to their personal wishes.

Inadequate

Is the service well-led?

Our findings

At the last inspection in May 2017 we identified a breach in regulation relating to staffing. We found there were insufficient numbers of suitably qualified, competent, skilled and experienced persons deployed in the service and this was a breach in regulation. Following the last inspection the registered provider sent us an action plan which identified how they were going to improve the service. At this inspection we found there were still insufficient numbers of suitably qualified, competent, skilled and experienced persons deployed in the service. We found our concerns identified throughout our inspection regarding staffing had not been identified by the interim manager and improvement team as a continuing concern from our previous inspection. This meant the registered provider had failed to address the issues relating to staffing.

We concluded this was a continuing breach of regulation 18 (1) (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found the service was being managed by an interim manager and an improvement team. The head of improvement told us the registered provider's improvement team had been brought back into the service to address quality concerns and to manage the service in the interim period until a new home manager was recruited and settled into the role.

Staff told us each day a different person was chosen as 'resident of the day' and this meant the person's care plan was reviewed, a meal of their choice cooked and their bedroom deep cleaned. On the morning of day three of inspection we found no one knew who the resident of the day was and we noted the previous day resident of the day tasks had not been fully completed. We spoke with the head of improvement and the interim manager and looked at the service improvement comprehensive action plan. We saw a number of actions were rated as high and medium priority along with a record of those actions that had already been completed. For example, we saw high priority actions for resident of the day information to be completed and staff training compliance percentage to be increased. In relation to these concerns the head of improvement told us the service will have moved to electronic care plans by April 2018. They further told us the service would not automatically hand back from the improvement team once a new home manager was in post as they wanted to ensure the new manager adopts and sustains the systems put in place. We will check that this has been progressed at the next inspection.

People we spoke with were unable to identify the interim manager. A person told us, "I don't know who the manager is these days." Another person said, "I didn't know there was a manager." A third person said, "The staff sort out my problems. I didn't know there was a manager." A relative told us, "We have seen too many management changes over the years. It makes your head spin."

Staff comments included, "All these changes in the management make staff moral low", "It worries us all about the management changes over the months" and "We need a manager that stays."

We asked staff whether they enjoyed working at Riverside Residential Home and we received a mixed response. Comments included, "Some of us it has pulled together. In general we've got a good team", "The

team as a whole is loads better. It used to be them and us (referring to the residential and Oakwell units)", "If staff morale is low, it reflects on the residents", "Things are worse since the last inspection" and "It never gets better here. I think this is the third manager. You don't know where you are."

Staff we spoke with told us told us they did not feel valued working at Riverside Residential Home. A staff member told us, "By [interim manager] yes, by Orchard (name of registered provider), no. You just don't feel valued by Orchard." A second staff member said, "They (the management team) seem to do nothing about it." A third staff member said, "We're quick enough to get into trouble, we're never praised."

Feedback from staff at the home about the interim manager and improvement team was not always positive. Comments included, "It feels a bit like we're in school", "Some staff will say no. Personally, I haven't had to approach [interim manager]" however one person stated "Oh yes, [interim manager] shows an interest."

On the first day of inspection a staff member left part way through the morning due to personal reasons. We observed a public falling out between the interim manager and staff member which took place in front of residents. Another member of staff told us the same thing had recently happened before. This conversation should have taken place privately and failed to respect this is someone's home.

At this inspection we found the system for auditing and quality monitoring was ineffective. This was clearly evidenced from the issues highlighted within the safe, effective safe and responsive domains of this report, including staffing levels, infection control risks, food and hydration needs, privacy and dignity and people did not always have access to activities. Staff we spoke did not always speak positively regarding the interim manager, improvement team or registered provider.

We asked staff whether they felt their concerns were listened to by the management of Riverside Residential Home. A staff member told us, "They (the management team) seem to do nothing about it." A second staff member said, "Because of how they (referring to staff) get treated by the office, a lot of staff won't pick up (cover shifts)." A third staff member said, "Staff are just so deflated having so many managers. They (referring to the registered provider) have to take responsibility for the demise of this home." We spoke to the interim manager who was aware of the recent changes in the home management and the subsequent negative impact on staff. They further told us staff meetings had been re-introduced to discuss areas relating to changes in Riverside Residential Home and to address any concerns staff may have.

Systems and procedures in place to monitor and address the quality of the service were always not robust. We saw audits were completed including care plans, medication, pillow, skin tears, accidents, infection control, mattress, pressure cushion, bed rail, weight loss and recruitment. We found weekly weights for people living at the home were not being carried out prior to improvement team taking over the running of the home. The deputy manager told us they were seeking an additional reference for one member of staff who had started employment in September 2014 as an audit of recruitment records had highlighted only one reference was on file.

We looked at a dining tool audit dated 3 January 2018 which had identified 'staff appeared quite stretched, so some residents did have to wait for support, which made their meal cool. Some people had their meal in front of them, but did not touch the food. Staff were busy supporting other people'. We found these concerns were still evident during our inspection. This showed previously identified issues were not addressed and therefore demonstrated a failure in the quality monitoring of by the registered provider to drive improvement.

We found the recording of position changes for one resident appeared unreliable with staff recording repositioning as having taken place at 08:30, 10:30, 12:30 and 14:30. A reposition change is where the person is supported to move into a different position in a chair or bed to reduce or stop pressure building on the area at risk. We discussed how precise these recordings were with the interim manager and head of improvement. The head of improvement asked the interim manager to ensure staff were accurately recording exact times when a person's position change took place. This meant it could not always be evidenced people were repositioned in an appropriate timeframe.

Staff meetings had not been held regularly at Riverside Residential Home since the last inspection in May 2017. Staff meetings enable relevant information to be shared with the staff team and provide an opportunity for staff to share their views about the service and care provided. Records showed one meeting had been held in July 2017, February 2018 and another one in March 2018. The interim manager, who started at the home in January 2018, told us monthly staff meetings had been planned going forward. We saw the February 2018 meeting had focused on reminding staff about various policies and procedures and the improvements required at the home, but it was poorly attended as only seven staff were recorded on the minutes. We looked at the March 2018 minutes and saw 20 staff members attended. The meeting focused on communication, documentation, home standards, meal time experience and staff management changes. We noted a discussion relating to rushed meal times and not enough staff being available to support meal times but there was nothing recorded against any items to indicate planned actions. This meant there was not always monitoring in place to make sure these actions had been appropriately completed.

We asked how people and their relatives were involved in decision-making at the home and informed about any changes. A relative told us, "We don't know if our thoughts and ideas are taken on board, nobody asks." The interim manager told us the registered provider's policy was to send out surveys to relatives twice a year, although feedback could be submitted on survey forms at any time. We saw blank survey forms in the home's reception and the interim manager said they were also available in the home's two units for people to complete should they wish to. A staff member confirmed the results of the relatives survey responded to by four individuals had been discussed at a staff meeting. The head of improvement told us the provider was carrying out an online survey for relatives and they were awaiting feedback.

The service had plans in place to further develop partnership working with other organisations, and stakeholders. The interim manager told us the open day planned at Riverside Residential Home was cancelled due to the infection control outbreak and new dates were being considered. The improvement manager spoke of their plans to approach local schools for more regular contact. They further said part of the provider's mission, vision and values is 'to be at the heart of the local community'. The interim manager discussed their ideas to work with students from local colleges with a focus on people's hobbies and interests. We will check that this has been progressed at the next inspection.

Under the Care Commission (Registration) Regulations 2009 registered providers had a duty to submit a statutory notification to the Care Quality Commission (CQC) regarding a range of incidents and changes to the service. During our inspection we identified the service had not submitted notifications to CQC regarding an accident/incident record of 28 July 2017 and in March 2018.

We concluded the providers programme to assess, monitor and improve the quality of service was not robust as breaches of the regulations persisted from the previous inspection. There was poor oversight by the registered provider which led to failures in leadership and contributed to a poor culture of governance at the home where staff did not feel empowered or valued.

This was a breach of regulation 17 (2) (a) (b) (Good governance) Health and Social Care Act 2008 (Regulated

Activities) Regulations 2014.

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 People were not supported to be actively engaged in activities and pastimes. Activity provision was limited. Regulation 9 (1) and (3) (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People's dignity and respect was not always respected. Regulation 10 (1) (2) (a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment We raised concerns about cleanliness at the home. Effective systems were not in place to reduce the risk and spread of infection. Regulation 12 (2) (h)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs We raised concerns around people's hydration needs. Fluid balance charts were not kept up to date. Regulation 14 (1) and (2) (b)

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 17 HSCA RA Regulations 2014 Good governance Governance systems in place were not always effective in identifying concerns and driving improvement. Regulation 17 (2) (a) (b)

The enforcement action we took:

We served a Warning Notice on the registered provider. They were told to be compliant with the regulation by 30 November 2018.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were insufficient numbers of suitably qualified, competent, skilled and experienced persons deployed in the service. Regulation 18 (1)

The enforcement action we took:

We served a Warning Notice on the registered provider. They were told to be compliant with the regulation by 30 November 2018.