Care UK Community Partnerships Ltd

Riverside

Inspection report

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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?	Good
Is the service responsive?	Good
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

This inspection was carried out over three days on the 31 October, 1 and 2 November 2016. Our visit on 31 October 2016 was unannounced.

We last inspected Riverside on 22 September 2014. At that inspection we found the service was meeting the regulation we assessed.

Riverside is a care home that provides accommodation, nursing and residential care. The home is registered to provide care for up to 90 people, but provides care for up to 87 people, who may be living with dementia, physical disability or require nursing care.

The home is located in a residential area of Manchester and caters for young people over the age of 18 as well as older adults.

The home is split into four units over two floors and there is a passenger lift serving both floors. On the ground floor there is the Shelley unit which is a 20 bedded unit providing care to younger adults and Bronte unit which is a 18 bedded unit providing residential dementia care. On the first floor there is the Nightingale unit which is a 22 bedded nursing care unit and the Lowry unit which is a 27 bedded unit providing dementia, nursing care. All rooms are single.

At the time of our inspection 79 people were living at Riverside.

The service did not have a registered manager in place. The manager took up post in December 2015 and was in the process of applying to the Care Quality Commission (CQC) for registration and had received a date for interview. A registered manager is a person who has registered with the CQC 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.'

During this inspection we identified four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and one breach of Care Quality Commission (Registration) Regulations 2009.

Some medicines were not managed safely for example we found instructions for care staff to administer topical creams did not accurately reflect the directions of the GP. This meant there was a risk that prescribed creams may not have been applied when required, which could have resulted in unnecessary discomfort for the person.

In addition we saw that the covert medication policy was not being appropriately adhered to for five people receiving their medication covertly. Covert medication is the administration of any medical treatment in a disguised form. This usually involves disguising medication for example by administering it in food and

drink; as a result, the person is unknowingly taking medication.

We saw that risk assessments were not being undertaken for oral hygiene and people did not have a plan of care to direct staff how to meet this this care need.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act. The application procedure for this in care homes is called the Deprivation of Liberty Safeguards (DoLS). During this inspection it was identified that the provider had not complied with their duty to notify us of all authorised DoLS. We saw evidence that during 2016 there were 11 authorised DoLs but the service had only notified us of four. This is a failure to notify the Commission of required events. In addition we saw that two of the DoLS authorisations had expired and had not been reapplied for. This meant two people were deprived of their liberty for the purpose of receiving care and treatment without lawful authority. The applications were made during the course of the inspection.

There were systems in place to monitor the quality of the service to ensure people received safe and effective care. However these audits had failed to identify the issues and concerns we found during our inspection and therefore required improvements.

Although the service employed a number of registered mental nurses (RMN's) and accessed community psychiatric nurse's (CPN's) as needed we noted that staff had not received training in understanding and managing particular mental health conditions such as depression and schizophrenia. We recommend that the service reviews training provided to staff in relation to the specialist needs of people who have mental health problems, to ensure staff provide care that reflects current best practice.

The home was clean and well maintained. However, we saw there was a risk of cross infection because hoists and some shower chairs were not clean and there was inappropriate storage of the hoist slings. This was addressed during the course of the inspection.

The service had good recruitment processes to ensure only suitable staff were employed.

Staff were receiving regular supervision and annual appraisals to enable them to carry out the duties they are employed to perform.

Staff understood how to recognise and report abuse which helped make sure people were protected. We saw any allegations of abuse had been dealt with appropriately and reported to the local authority safeguarding team.

People had access to healthcare services and we saw specialist advice was sought in a timely manner. For example, referrals had been made to the speech and language therapists when it had been identified that people were having difficulty swallowing.

Attention was paid to people's diet and people were supported to eat and drink in a way that met their needs. For example people were asked about their personal preferences and special diets such as diabetic or soft diets were provided accordingly.

People received person-centred care and we saw privacy and dignity was respected.

The home employed the services of designated activity coordinator and we saw a range of activities were

available and based on the personal preference of people living at Riverside.

The visitors we spoke with told us they thought Riverside was a lovely, friendly care home and they were happy their relatives were well looked after.

From our observations of staff interactions and conversations with people, we saw staff had good relationships with the people they were caring for and respected their privacy and dignity. The atmosphere felt friendly and relaxed.

The home's statement of purpose included information about how to make complaints, which people were provided a copy of when they moved into the home. There was a system in place for receiving, handling and responding to concerns and complaints. One relative we spoke with told us they had raised a concern and were satisfied with the way it was handled.

Staff spoken with understood the need to obtain verbal consent from people using the service before a task or care was undertaken and staff were seen to obtain consent prior to providing care or support.

We looked at the staff duty rosters in place for nurses, care and ancillary staff and saw these had been planned three weeks in advance. We saw where there was a need to cover unallocated shifts due to staff absence, gaps identified in advance were filled by agency staff, casual workers or existing staff who had volunteered to cover the shifts. During the inspection we saw that there was appropriate numbers of care staff and nurses providing care, but there were only two kitchen staff and one laundry worker to provide an ancillary service for 85 people.

We recommended that a review of kitchen and laundry staff is undertaken so the registered provider can be satisfied they have sufficient numbers of ancillary staff.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not always safe. Shortfalls were found in the administration and recording of some medicines. Oral hygiene was not being risk assessed and plans of care were not implemented for this particular care need. Appropriate checks had been undertaken to ensure suitable staff were employed to work with vulnerable people.	**Requires Improvement**
Is the service effective? The service was not always effective. Two people living at Riverside were deprived of their liberty for the purpose of receiving care and treatment without lawful authority because their DoLS authorisations had expired. We noted staff had not undertaken training in understanding and managing particular mental health conditions such as depression and schizophrenia. Staff received induction training and support they required to fulfil their roles and meet people's needs.	**Requires Improvement**
Is the service caring? The service was caring. Staff were seen to be kind and caring in their interactions with people. People looked content and well cared for. Visitors spoken with told us they thought their loved ones were well cared for.	**Good**
Is the service responsive? The service was responsive.	**Good**

We saw that people's needs were assessed prior to admission to ensure the home could meet their individual needs.

There was a system in place for receiving, handling and responding to concerns and complaints.

People were offered a range of activities suited to their individual interests and preferences.

Is the service well-led?

The service was not always well led.

At the time of this inspection the manager was not registered with the Care Quality Commission.

The registered provider has a duty to notify us of certain incidents and this had not been done.

Audit systems were being used to aid service improvement; however they had failed to identify the issues and concerns we found during our inspection.

Care Quality Commission

Riverside

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 was carried out over three days on the 31 October, 1 and 2 November 2016. Our visit on 31 October 2016 was unannounced. The inspection team consisted of two adult social care inspectors and a specialist adviser, who had knowledge and experience of caring for people with a learning disability.

Before the inspection we reviewed the previous Care Quality Commission (CQC) inspection report about the service and notifications of incidents that we had received from the service. We looked at the Provider Information Return (PIR) before our visit. A PIR is a document that asks the provider to give us some key information about the service, what the service does well and any improvements they plan to make.

We also contacted the local authority commissioners to seek their views about the home. We did not receive any information of concern.

During our visits we spoke with regional director, the operations support manager, the lead clinical support nurse, the manager, the deputy manager, two unit managers , the head housekeeper, two nurses, two carers, the cook, the head of maintenance, three visitors to the home and three people living at Riverside .

We looked around the building including a sample of bedrooms on all four units, all of the communal areas, toilets, bathrooms, the kitchen and the garden areas.

We examined the care records for six people living at Riverside, medicine administration records, the recruitment and training records and records relating to the management of the home such as the quality assurances systems. We also looked at four staff personnel files and four supervision records.

Requires Improvement

Is the service safe?

Our findings

We looked at the systems in place for the management of medicines and reviewed policies and procedures in place relating to the administration of medicines.

We saw there was a medication policy but the policy did not provide staff with guidance in relation to medicines not being administered due to the person being asleep. On reviewing medication administration records, we found that one person had missed their medication on ten occasions over a 15 days period because they were asleep at the time of the medicines being administered. This meant the person was not receiving their medication as prescribed by their GP which could be detrimental to their health and wellbeing.

We asked a nurse about the safe handling of medicines to ensure people received the correct medication at the right time. Answers given along with our observations demonstrated medicines were administered competently but there were some isolated lapses in good practice. For example, we saw one person required their medicine to be administered 30 minutes before breakfast, yet we saw it administered after breakfast. This was discussed with the manager and during the course of the inspection we were told they had introduced pre breakfast medication administration to rectify the shortfall.

We saw one person had been prescribed a short course of antibiotics to be taken three times a day for five days. The MAR sheet showed the medicine had been administered three times a day for six days. This meant the person had not received the medication as prescribed by the GP.

Whilst the provider's policy stated all 'as necessary' (PRN) medicines for example paracetamol, should be supported by a protocol. We saw they were not always supported by robust written instructions, which described situations and presentations where PRN medicines could be given. For example, we saw a person was prescribed pain relief medicines to be taken one to two tablets up to four times a day yet no protocol existed. This meant there was a risk that adequate pain relief was not being administered.

Creams and ointments were prescribed and dispensed on an individual basis. The creams and ointments were appropriately stored and dated upon opening. The responsibility for the application of creams was delegated by nurses to care staff. The original MAR sheet instructions were transcribed onto a topical MAR sheet from which the care staff took their instructions. We saw that the transcribed instructions were inaccurate. For example, we saw one person was prescribed cream that required to be applied twice a day, yet when this had been transcribed onto the topical MAR the instruction said twice daily PRN. We saw nurses recorded the application of the cream on the original MAR as applied on15 occasions in the past eight days. However, the topical MAR showed the cream had been applied on only seven occasions. We found another example where a person using the service who had been prescribed cream for treatment of psoriasis of the scalp. The MAR sheet recorded the prescriber's instructions to apply the cream two to three times a day to the scalp. The transcribed instructions on the topical MAR sheet stated "apply as required – prn". The nurses had recorded on the original MAR the application of the cream twice daily yet the topical MAR recorded the cream had only being applied once in the past two weeks. This meant there was a risk that people may not

have received prescribed creams as intended by their doctor, which could result in unnecessary discomfort for the person.

We looked at the MAR sheets and saw in one instance somebody was prescribed medicines to be administered on alternate nights and the monitored dosage system showed the medicine was dispensed alternate nights. However when we looked at the MAR sheet we found nurses had signed the sheet denoting the medicine had been administered every night. This meant that although the person was receiving their medication as prescribed there was a risk that nurses were signing the MAR sheet without any reference to the medicines administered and the written record was inaccurate.

At the time of our inspection we were told that five people were receiving their medicines in a covert way. Covert medication is the administration of any medical treatment in a disguised form. This usually involves disguising medication for example by administering it in food and drink. As a result, the person is unknowingly taking medication. We found the service was not adhering to their own medicines policy. The policy set out the procedure to follow to create a legal framework for the administration of covert medicines. On three records we saw no evidence a GP had been involved in the process or that a best interest meeting had been held. We saw no written plans of care for how the medicines should be administered or whether attempts should be made to administer the medicines with the person's knowledge. During the course of the inspection the manager told us that they had contacted the GP who was reviewing all five people's medication and a best interest would be arranged if required.

The above examples demonstrate a breach of regulation 12 (1) (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, safe administration and management of medicines

Some prescription medicines contain drugs that are controlled under the Misuse of Drugs legislation. These medicines are called controlled drugs (CDs). We saw controlled drug records were accurately maintained and that the administration of controlled drugs and the balance remaining was checked by two appropriately trained staff.

We checked to determine the prescribing and administration of antipsychotic and anxiolytic medicines to treat the behavioural symptoms of dementia. We found no evidence these medicines were being used or prescribed inappropriately. This meant excessive sedation; accelerated cognitive decline and increased mortality were not a risk factor for people with dementia at the home.

Risk assessments were in place which covered areas such as nutrition, moving and handling, skin care and bed rails. These provided information to staff on how to manage identified risks. For example, manual handling assessments detailed the method of transfer, any equipment to be used and the number of staff required.

We saw detailed plans of care in relation to prevention of pressure ulcers and wound care. In one care file we saw that that a person had been swiftly and appropriately referred to the tissue viability nurse for advice due to a moisture lesion and some wounds. We saw that each wound had been identified on a body map, had a wound description and a photograph with wound measurements, a detailed plan of care, evidence of when the wound was dressed , what dressing had been applied. In addition there was an evaluation chart and a progress report for each wound. This demonstrated good practice in relation to wound care because they were able to track and monitor any deterioration or improvements for each individual pressure ulcer or wound .

Staff we spoke with had a good understanding of the risks people were exposed to and how to control them.

However in the five care files we looked at there was no evidence of an oral hygiene risk assessment or a plan of care to meet this care need. This meant there was a risk that people may not be having this care need appropriately met.

The above examples demonstrate a breach of Regulation 12 (1) and (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

The manager showed us the dependency tool they used to calculate staffing levels on each unit which was based on the assessed dependency levels of need for the people who used the service. The manager said they reviewed this on a monthly basis or more frequently if people's dependencies changed or there were new admissions. The tool calculated the number of staff hours required and we saw the home was working above these levels. The manager told us that due to vacancies on one unit the home were currently not admitting people onto that unit and generally they would not admit more than one person per unit to ensure the person was safely admitted to the home and that their needs were appropriately assessed and planned for.

When we spoke with staff they told us that they felt there was enough care staff to meet the needs of the people who used the service. However staff spoken with also told us there was not always enough ancillary staff in the laundry and kitchen at busy times of the day. The home manager told us staff were allocated to work in specific areas at particular times of the day, with ancillary staff having their own rota which was organised by the head housekeeper. Therefore staffing levels varied slightly within different areas of the home.

We examined the staff duty rosters in place for nurses, care and ancillary staff and saw these had been planned three weeks in advance. We saw where there was a need to cover unallocated shifts due to staff absence, gaps identified in advance were filled by agency staff, casual workers or existing staff who had volunteered to cover the shifts

Walking around the building we observed the number of staff on duty. Whilst there was an appropriate number of care staff and nurses providing care, there were only two kitchen staff and one laundry worker to provide an ancillary service for 85 people.

We recommended that a review of kitchen and laundry staff is undertaken so the registered provider can be satisfied they have sufficient number of ancillary staff to meet all of the needs of the people living at Riverside.

We looked at six staff files which showed procedures were in place to ensure the staff recruited had the appropriate qualities to protect the safety of people who used the service. The files contained job descriptions, proof of identity, an application form that documented a full employment history and accounts for any gaps in employment, a medical questionnaire, a job description, references and interview notes. Pre-employment checks had been carried out with the Disclosure and Barring Service (DBS).The DBS identifies people who are barred from working with children and vulnerable adults and informs the service provider of any criminal convictions noted against the applicant.

During the inspection we saw all bathrooms and toilet areas were clean and contained wall mounted liquid soap and paper towel dispensers. However we saw a hoist on Shelley unit, a shower chair on the Lowry unit and an assisted bath chair on Bronte unit were dirty and required cleaning. We saw that the cleaning of this type of equipment was not included in the cleaning schedules. During the course of the inspection we were informed by the manager that all hoists and shower chairs in the home had been cleaned and we saw that

they had been included in the cleaning schedules.

The manager and deputy manager told us they undertook an informal daily walk around the home and we saw a formal documented walk around was recorded twice or three times a week. This was to ensure high standards of cleanliness were maintained. We also saw a twice yearly infection control audit was undertaken; the most recent audit was dated 25/10/16.

During our inspection we saw personal protective equipment (PPE) such as disposable aprons and gloves were available throughout the home as was hand sanitiser, which would help reduce the risk of cross infection.

We saw the use of colour coded mops for cleaning and we saw good stocks of cleaning products, which helped staff to maintain good standards of hygiene and cleanliness throughout the home. All cleaning products were in a locked cupboard to ensure people's safety. During the course of our inspection we saw that data safety sheets for the cleaning material used by the home were in place and made available on the cleaning trolleys used on each unit, as per the requirements of the Substances Hazardous to Health (COSHH) Regulations. COSHH is the law that requires employers to control substances that are hazardous to health.

We saw evidence of ongoing and planned refurbishment and maintenance work. For example we saw the corridors, door frames and bedroom doors on Shelley unit had recently been repainted. We saw new kitchenette's had been fitted on the Shelly, Lowry and Nightingale units. The maintenance man provided us with information that earlier this year the Nightingale unit had a new assisted bath fitted and one of the bathrooms on the Shelly unit had been re-tiled, painted, new lights and new handrails fitted around the toilets and new flooring had been laid. This demonstrated that the premises were being properly maintained for their intended purpose.

During this inspection we saw that appropriate safety checks had been carried out to ensure people were cared for in a safe environment. For example we saw evidence of gas and electric safety certificates, hoist and lift servicing, asbestos checks, nurse call bell checks, window restrictors, thermostatic mixer valve checks to ensure safe water temperature delivery, a check of bedroom temperatures and safety checks of bedrails and grab rails. In addition we saw monthly checks of emergency lighting, emergency exits, firefighting and evacuation equipment and fire alarms. We saw that regular fire drills were undertaken the most recent being completed on 9 September 2016.

We saw ta fire evacuation plan in the main reception, a fire evacuation box which included items such as torches, a first aid box, high visibility vests and emergency contact details. In addition we saw that everybody had a Personal Emergency Evacuation Plan (PEEP's). These plans detailed the level of support the person would require in an emergency situation. This meant in the event of an emergency evacuation the risk to people being evacuated effectively would be reduced.

All of the visiting relatives spoken with told us they felt confident that their relative was safe and well cared for. One person said, "I have no worries about the care here all the staff are excellent." Another person said "I have peace of mind that [their relative] is safe, the staff are everything I could wish for." They told us that they visited every day and see what goes on they had not seen anything of concern.

Staff we spoke with had an understanding of their role in protecting people and making sure people remained as safe as possible. Staff had access to a safeguarding adults policy and a copy of the local authority's multi-agency safeguarding adult's policy. We reviewed the safeguarding records and saw

incidents had been appropriately investigated by the local authority safeguarding team and Riverside had appropriately notified the Commission. Where further actions had been recommended by the local authority or by the registered manager or the regional clinical lead as a result of safeguarding investigation we found these had been completed. For example following a recent safeguarding investigation all the nurses had undertaken wound care training. In addition weekly clinical risk meetings had been implemented with the clinical lead and a nurse from each unit to discuss any infections people may have acquired any wounds or any falls. This meant that lessons had been learnt as a result of the investigation and direct action had been taken in an attempt to prevent a potential recurrence of the incident.

In addition we saw staff had access to a Whistle Blowing policy. The Whistle Blowing policy is a policy to protect an employee who wants to report unsafe or poor practice.

Requires Improvement

Is the service effective?

Our findings

The home manager, and staff spoken with were aware of the Mental Capacity Act 2005 (MCA) and staff training records indicated that all staff had undertaken MCA training as part of their induction process. The MCA protects the human rights of people who may lack capacity to make decisions for themselves. The MCA sets out what must be done to make sure the human rights of people, who lack mental capacity to make decisions, are protected. All of the staff we spoke with had a clear understanding of the MCA and knew to share their concerns with the home manager to make a referral to the local authority.

The Care Quality Commission is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS) and to report on what we find. This legislation sets out what must be done to make sure the human rights of people who may lack mental capacity to make decisions are protected. The Deprivation of Liberty Safeguards (DoLS) provides a legal framework to protect people who need to be deprived of their liberty to ensure they receive the care and treatment they need, where there is no less restrictive way of achieving this.

We checked people's care records to see if 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. Where people were subject to DoLS the relevant person's representatives (RPR's) and appointed independent mental capacity advocates (IMCA's) were seen to have been involved in decision making and involved in the regular reviews of care needs.

We saw from care records and associated administrative files some people had appointed attorneys by way of a lasting power of attorney (LPA) or where people lacked mental capacity, had deputies appointed by the Court of Protection. A LPA is a way of giving someone you trust the legal authority to make decisions on your behalf if you lack mental capacity to make decisions for yourself. Care records recorded where attorneys and deputies had been involved in decision making or where reviews of care plans had been undertaken.

However, we found two previously authorised DoLS had expired in July and September 2016 respectively and a new application for each person had not been submitted to a supervisory body such as the local authority. This meant the liberty and freedom of both people was being unlawfully restricted whilst living at the home. Following the discussion with the home manager and deputy manager they confirmed they were continuing to follow the requirements in the expired DoLS authorisation and immediately made applications for an urgent DoLS for both people.

The above examples demonstrate a breach of regulation 13 (5) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our inspection, we observed staff gaining people's consent to support them.

People's care records contained the necessary documents signed by themselves or their legal representative to consent to the care and treatment being provided. It was apparent from speaking with

staff they had a good understanding of how and why consent must be sought to make decisions about specific aspects of people's care and support.

We spoke with the manager about the use of restraint and any policy documents to underpin restraining methods. We were told all forms of physical restraint were not a feature of the service. Any need to protect people or staff from harm was provided by attempts to de-escalate situations. Our subsequent discussions with care staff showed the philosophy of care was well understood.

People using the service expressed positive views about the care and support being provided. They told us they felt the staff had the appropriate skills and knowledge to do their job and the staff skill mix was good. One person said, "The staff help me to get dressed, they help me with my movement and use the hoist to help me stand up. They seem to know what they're doing. I have no problems with them." Another person said, "The staff look after me well, I am comfortable."

We saw new employees received relevant written information about their role and responsibilities to support and guide them through their induction into the service. From April 2015, staff new to health and social care should be inducted according to the Care Certificate framework and we saw this was included in the homes induction. This replaces the Common Induction Standards and National Minimum Training standards.   Staff spoken with told us they had received good induction training prior to working with people who used the service. They told us they had undertaken a two week period of induction in which time they received training in essential topics relating to their work.

As part of the induction process staff spent five days shadowing another worker with the same job role. They said, "We do shadowing until we become competent in tasks such as delivering personal care, moving and handling people and keeping the home clean and hygienic." Shadowing involves working with another employee who can teach, or can help the person to learn aspects related to the job.

We examined the overall training record and six staff personnel files which contained training certificates to show staff had received the appropriate training to carry out their role effectively.   From looking at the training certificates, training records and from speaking with staff we saw they had undertaken mandatory training such as moving and handling, hoist training, first aid, food hygiene, fire awareness, safeguarding and whistle blowing. Additional training in venepuncture (a medical procedure to withdraw a blood sample or for an intravenous injection) wound care, catheter care, diabetes, skin integrity and Boots pharmacy medicines management had also been undertaken.

We saw staff had a 'learning and development (L&D) plan' which confirmed this and showed the dates when training had been completed and planned refresher training dates were in place. The home manager told us staff members were supported to obtain formal qualifications in Health and Social care at National Vocational (NVQ) level two or a level three diploma.

Whilst the service had a comprehensive L&D plan and employed a number of registered mental nurses (RMN's) we noted the L&D plan did not include training in understanding and managing particular mental health conditions such as depression and schizophrenia. Also, the L&D plan did not include staff training in providing people with end of life care. Staff supporting people at the end of their life or people with mental health issues should be properly trained to undertake their work effectively and appropriately. This would help to make sure the best outcome is achieved for those people. The home manager told us they would contact the local adult community mental health team to enquire about introducing mental health awareness staff training. They also told us they were introducing the Six Steps end of life programme and were in the process of arranging December training dates with an external training provider. This training

had been previously arranged and was cancelled by the external provider. The programme aims to enhance end of life care through facilitating organisational change and supporting staff to develop their roles around providing end of life care.

We recommend that the service finds out more about training for staff, based on current best practice, in relation to the specialist needs of people who have mental health problems.

Records showed all staff had received an appropriate number of one to one supervision meetings since starting their employment at the service. The home manager told us that following staff induction and a probationary period, staff members were provided with regular supervision sessions. At this stage any further training needs were identified and organised. In addition to this staff meetings were held every two to three months and where staff were unable to attend the meetings, the meeting notes were made available for them to read.

There was an ongoing annual staff appraisal system in place to discuss and evaluate the quality of staff individual performance and where best practice or practice improvement was demonstrated. A registered nurse (RN) who we spoke with told us whilst there was no clinical supervisor in place at the home the RN's were able to update their competences via local GP surgeries, with the district nurses or community psychiatric nurses (CPN's). The registered nurse competences are designed to support the development of registered nurses and enable them to gain recognition for their knowledge, skills and competence in their daily roles. They reflect all the domains in which registered nurses may be required to practice and apply to all registered nurses regardless of area of employment.

People living at Riverside had varying degrees of support needs ranging from mostly independent to requiring increased levels of support. Some people were able to select their food choices with assistance from care staff. We saw that people had choice about what they wanted to eat and drink and where required people were supported to eat and drink. Daily record sheets indicated the type and amount of food people had eaten. Where people had been assessed as having a risk associated with eating and drinking, such as choking, people had received specialist assessment, and advice was followed.

The care records also showed that people had access to external healthcare professionals, such as hospital consultants, specialist nurses, physiotherapists and GPs, who contributed to the care records. We saw evidence in care records of multi-disciplinary team meetings involving a Speech and Language Therapist (SALT) and physiotherapist. Other care records showed attention was paid to general physical and mental well-being; including annual health action check records which recorded people's weight, dental checks, optician and gender specific annual health checks.

Accommodation at the home was provided in four separate units over two floors which can be accessed using a passenger lift. When we walked around the home we found the layout of the building took into account the needs and dependency of the people who lived there. In particular adaptations for people living with physical disabilities such as stand hoists, specialist baths and chairs helped to promote people's dignity and independence wherever possible. A separate unit was in place specifically for people living with dementia. All corridors in the home had handrails and were wide enough for wheelchair access. People who used the service had access to small enclosed outdoor garden which provided a safe, secure and private leisure area.

Good

Is the service caring?

Our findings

The visiting relatives we spoke with told us they were very happy with they care their relative received. They told us the staff were good at respecting people's privacy and dignity and one relative said "I have great respect for the them [the staff]." However, one visiting relative told us some staff were kinder than others. One person living at Riverside told us they were happy with their care and had everything they needed.

There were no restrictions as to when people could have visitors and we saw relatives and friends coming and going throughout the inspection. The staff appeared to know the visitors and have good relationships with them. One relative said, "I can visit when I want and I am always made to feel very welcome." Another comment was "They [the staff] make me feel like part of the family, this is a very friendly home and I am pleased with the care of [their relative]."

We observed that people were all well-groomed and appropriately dressed. Staff were observed to demonstrate a good knowledge of the people who used the service and their individual personal preferences. The atmosphere felt calm and relaxed and people were seen to be freely moving around the units between the different communal areas or staying in their room if that was their preference. People looked comfortable and relaxed in their surroundings and in the company of staff.

We saw that staff were kind, patient and respectful in their interactions with people. For example we observed one person come out of the toilet looking quite distressed and we saw a member of staff quickly assist them in a calm and dignified way.

Information was present in people's care records about their individual likes and dislikes, hobbies and interests. For example we saw one person liked to have quiet time in their room in the afternoon and listen to music or watch TV. Another person liked to have their sensory light on when they were in bed. This personalised information helped staff to provide care and support based on people's personal preferences. Information on people's lives such as their school life, adult life and work life was present to help staff better understand the individual.

End of life care plans were in place which provided staff with personal information on how the person wanted to be treated at the end of their life. At the time of this inspection one person was receiving end of life care and we saw the service had appropriately accessed the tissue viability nurse (TVN) and the person's GP. The manager told us that as part of end of life care they made every effort to support the family and would facilitate overnight stays if the family requested it.

The home manager told us that details of local advocacy services were available on request. An advocacy service provides an independent advocate who is a person who can help access information on a person's behalf and / or represent a person's wishes without judging or giving their personal opinion. The manager told us that two people were currently supported by an Independent Mental Capacity Advocate (IMCA). An IMCA helps to support a person to make decisions, representing the person's views and act in the person's

best interests.

Good

Is the service responsive?

Our findings

We saw that people's needs were assessed prior to admission. This information helped to ensure the home could meet the individual assessed needs of the person.

The home manager said people were encouraged to come and have a look round the home and if it was appropriate and the person was able they would be invited to visit the home and perhaps have lunch and meet the staff and other people living at the home before they made a decision about moving in. The home manager said that at the initial visit the person or their representative if that was more appropriate would be encouraged to attend the home unannounced before making a decision to move in. Relatives spoken with confirmed this.

We saw that information booklets were available for people about the home and the care provider, Care UK.

People living at Riverside told us staff listened to them and supported them to do things for themselves where possible. They felt that staff knew their preferences for their care. One person told us, "The staff help me to do some things like get dressed. I can do other things for myself, but they're alright with me and they are helpful."

Relatives spoken with told said, "I always receive a phone call from the staff if my wife has seen the doctor for any reason. They keep me informed". Another relative told us that their relative's general wellbeing had improved since they had moved to the home because staff made sure the care and support they received was tailored to meet their individual needs".

We saw staff spoke to people in a friendly manner and respected their wishes.

A group of four staff spoken with were able to tell us about the personal history of people and their care preferences. They told us any information about people's care could be found in individual care plans and information about each person was shared at staff handovers. One staff member said, "We read the written notes made in the care plans especially the person's initial pre assessment form. That gives us good information about how we can meet the person's needs. The handover is important especially if we have a new staff member or agency workers." A RN said, "A nursing assessment is used to build the persons care plan for example, their weight and dietary requirements. We always complete a body map of the person during the admission process which is done on the day the person moves into the home. Most of the general information is gathered within 24 hours of the person's admission. A GP is allocated as soon as possible at the admission stage, so that the person's medicines and health issues are recorded with the person's and or their relative's involvement. The care plans are very person centred". A domestic assistant said, "Before a person is admitted to the home the bedrooms are re painted, and repairs are done and then we always give the bedroom a deep clean to make sure it is fit for anybody to move into".

We examined six people's individual care records and care assessments which showed care plans had been

reviewed with their participation or their representatives' involvement. Care plans had been updated to reflect any changes to help make sure continuity of people's care and support. Care plans were person centred, comprehensive and clearly detailed the care to be provided. They had been immediately updated and reviewed as soon as people's medicines or health needs had changed.

Activities were planned in advance by the activity co-ordinator's and people living at Riverside. We saw from looking at people's care records that activities were planned and provided based on people's individual interests and hobbies. For example, we saw that one person who enjoyed gardening had been involved in growing tomatoes and knitting group had been facilitated for a small group of people. Other activities included, bingo, visiting entertainers, arts and crafts visits to places of interest, visits from local churches. The activity co-ordinator we spoke with told us they always ask people their opinions and encourage them to be involved in decisions about what they want to do. During the inspection we saw a Halloween party had been organised and two people were escorted to a local church afternoon social club. At the time of our inspection we were told by one of activity co-ordinators that two co-ordinators were employed who provided activities over five days but the intention was to provide a seven day activity programme when two other co-coordinators returned from maternity leave in the New Year. We saw that people had a separate activity care plan and there was a separate individual record of the activities people participated in or were offered and refused. A person using the service said, "We're going out to the community centre today. I have made friends there and I look forward to going."

People and visiting relatives told us they knew how and who to raise a concern or complaint with. A copy of the complaints procedure was included in the home's statement of purpose which was given to people on admission and indicated who to contact should they need to raise a complaint and the timescales for action in response to the complaint.

We looked at the records of complaints and saw that during 2016 four complaints had been received. The showed the complaints had been investigated and provided details of the complaint, the action taken and the feedback provided to the complainant. We saw that all complaints and concerns were recorded on a computerised system that was then reviewed by the company's complaints team and feedback would be proved to the regional director and manager as appropriate.

People told us that if they were unhappy they would not hesitate in speaking with the home manager or a staff member. When asked about the home's complaints process a person using the service said, "I've never had any need to complain and I've been here four years. If needed to complain, I'd just speak to one of the staff. They're alright and easy to talk to."

Requires Improvement

Is the service well-led?

Our findings

It is a requirement under The Health and Social Care Act (2008) that the manager of a service like Riverside Care Home is registered with the Care Quality Commission (CQC). When we visited, the service did not have a registered manager in place. However a home manager had been in post since November 2015 and had submitted an application to register with CQC. The home manager was present during the inspection and was supported in their role by a registered nurse who was responsible for nursing clinical governance and any clinical decisions that needed to be made.

Part of a registered managers or registered providers responsibility under their registration with the Care Quality Commission is to have regard, read, and consider guidance in relation to the regulated activities they provide, as it will assist them to understand what they need to do to meet the regulations. One of these regulations relates to the registered managers/registered provider's responsibility to notify us of certain events or information. We checked our records before the inspection and saw that accidents and incidents that CQC needed to be informed about had been notified to us by the home manager. This meant we were able to see if appropriate action had been taken by management to ensure people were kept safe. However, during the inspection we found that during 2016 the registered provider had not notified us about seven DoLS that had been authorised by the local authority. The CQC require this information, so that where needed, we can take follow-up action. We were sent these notifications retrospectively following the inspection.

The above examples demonstrate a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

Systems were in place to monitor the quality of the service to ensure people received safe and effective care were in place. The home was audited on a quarterly basis by a member of the clinical and care governance team and visited monthly by the regional director. We examined records, which showed regular audits and checks were undertaken on all aspects of the running of the service. We saw evidence in the form of reporting systems and audits for wound care, nutritional reviews, medicines audits, care plan audits, risk assessment audits and infection control audits that had been completed regularly and were up to date. Additional audits, checklists and reports had been undertaken for kitchen cleaning, all areas of the home cleaned by domestic staff and food served. Checks were made on the buildings physical environment included safety checks of floor surfaces, areas requiring decorating, stairways, lighting, ventilation and windows. These identified where improvements were needed and the information was fed into a service improvement plan (SIP). Following this, all SIP data was shared with the regional director, operations director and chief executive to inform them of auditing outcomes and activity at the home, to determine what action would be taken to address any identified issues. Records were in place to show the action taken to address improvements identified and timescales. However these audits had failed to identify the issues and concerns we found during our inspection. It was of particular concern that their systems had failed to identify that two people were being deprived of their liberty because their authorisations had expired and had not been reapplied for.

The above examples demonstrate a continued breach of regulation 17 (1) (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Accidents and incidents were recorded and had been regularly monitored by the home manager to ensure any trends were identified, monitored, investigated and results were evaluated. In addition, any safeguarding concerns were recorded and checked for trends. The home manager told us there had been no identifiable trends in the last 12 months and this was confirmed from the records we looked at.

We examined records to show staff individual supervisions and appraisals, were scheduled in advance alongside team meetings and manager briefings. Notes of the meetings were kept to ensure an accurate account of people's verbal contribution. The notes also confirmed quality and safety at the home was discussed on a regular basis. The home manager told us staff meetings were in place to share information and motivate staff which enabled them to be involved in decisions about how the service is being run.

Discussions with the home manager and staff demonstrated they had a good understanding of the aims and objectives of the service. The home manager told us they wanted to ensure that people received the best care possible whilst at Riverside and they wanted to make sure people who used the service had as much control and choice as possible about their care through good quality support and using a person centred approach.

The home's statement of purpose contained a philosophy of care which helped to ensure people's care was supported through the home's charter of rights which included choice, privacy and confidentiality, dignity and individuality, fulfilment and advocacy. However, it was noted that point 5. Care plans stated 'prior to moving into Hollins Park all residents will have a personal care plan devised for them.' Hollins Park is another care home owned by this provider. This meant the statement of purpose contained inaccurate information and required updating so people have up to date, accurate information.

There was a clear management structure in place and staff were aware of their roles and responsibilities. To support the home manager each of the four units of the home had a unit managers. Staff spoken with made positive comments about the way the home was being managed and said, "Staff here are very good, there's a good atmosphere and we all pull together. They told us they felt the management team responded well to the needs of people who used the service and staff members. One staff member said, "We're like one big family here. We all know each other and the people who live here well." Staff knew what was expected of them and understood their role in ensuring people received the support they required and their responsibility to provide this in a caring way.

Meetings to give people using the service and staff the opportunity to say what they liked about the service provided and what improvements could be made, if any, were held frequently. Notes of the meetings were kept to ensure an accurate account of people's verbal contribution. Notes of staff meetings held also confirmed quality and safety at the home was discussed on a regular basis. The home manager told us staff meetings were in place to share information and motivate staff which enabled them to be involved in decisions about how the service is being run.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 Registration Regulations 2009 Notifications of other incidents The registered provider had failed to notify CQC of all incidents that affect the health, safety and welfare of people who use services.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment We found that the registered provider had not protected people against the risks associated with the safe administration and management of medicines. Regulation 12 (1) (2) (g) We found that the registered provider had not ensured appropriate risk assessments and planning care for oral hygiene. Regulation 12 (1) and (2) (a) (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment A service user must not be deprived of their liberty for the purpose of receiving care and treatment without lawful authority.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Systems to monitor the safety and quality of

the service required improvements to ensure compliance with the regulations. Regulation 17 (1)