Five Rivers Living LTD.

Five Rivers Living

Inspection report

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Ratings

Overall rating for this service	Inspected but not rated

Is the service safe?	**Inspected but not rated**
Is the service well-led?	**Inspected but not rated**

Summary of findings

Overall summary

About the service
Five Rivers Living is a purpose-built home offering residential care for individuals both over 65 and under, those with dementia related needs, physical disabilities or end of life care. The home can accommodate and care for up to 50 people who require accommodation and support with personal care.

People's experience of using this service and what we found
The provider did not have robust systems in place to ensure people were protected from avoidable harm. Risks to people's health and safety were not always regularly reviewed, for example in relation to pressure area care. Care plans and risk assessments did not contain adequate information for staff to know how to support people to manage their behaviours safely.

Improvements were required in relation to medicines management to ensure this was safe and people received their medicines as prescribed.

There were mixed views about staffing levels at the service. Some people and staff felt there were not always sufficient numbers of staff, particularly at weekends, others felt staffing was adequate to meet people's needs. There was no dependency tool in place to assess people's needs on a regular basis to determine staffing levels were appropriate to meet people's needs safely.

Following accidents and incidents there was a lack of analysis and there was no debrief for staff so that lessons could be learnt. This meant that opportunities to learn from incidents could be missed.

Quality assurance systems were not always effective at identifying any areas of concern for example, areas of medicines management. There was a clear lack of provider oversight to ensure systems in place were being followed and used to drive improvement at the service and to ensure the registered manager was fully supported in their role.

People and staff felt confident about the leadership of the service and the registered manager who they described as respectful, professional and responsive. However, some comments we received referred to the registered manager as often being very busy and preoccupied so people and staff did not always feel they were available to talk to her.

Relatives felt their family members were safe living at the service. Most staff told us they had completed training in safeguarding vulnerable people from abuse. Staff we spoke with understood what safeguarding was and how to recognise abuse, but two staff did not understand what the term whistleblowing meant. This did not assure us that all staff knew how to report concerns to the relevant people.

Robust recruitment checks had been completed to ensure only suitable people were employed to work at the service.

The service had sufficient and safe infection prevention and control measures in place. Government guidance in relation to COVID 19 had been followed consistently.
For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
This service was registered with us on 01 May 2019 and is the first inspection since their registration.

Why we inspected
We received concerns in relation to the management of medicines, people's care needs, staffing and leadership of the service. As a result, we undertook a focused inspection to review the Key Questions of Safe and Well-Led only.

We have found evidence that the provider needs to make improvements. We have not rated this service, as a comprehensive inspection is required of the service, covering all the domains, before a rating can be given. Please see the Safe and Well-Led sections of this full report.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted as part of our Thematic Review of infection control and prevention in care homes.

You can see what action we have asked the provider to take at the end of this full report.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service.

We have identified breaches in relation to the safe care and treatment of people, in particular regarding the safe management of people's medicines and risk management to ensure people are kept safe. We also found a breach of regulation regarding effective governance arrangements.

Follow up
We will continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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. Details are in our well-Led findings below.	**Inspected but not rated**
Is the service well-led? The service was not always well-led. Details are in our well-Led findings below.	**Inspected but not rated**

Five Rivers Living

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service.

Inspection team
The inspection team consisted of two inspectors, a medicines specialist advisor and an expert by experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Five Rivers Living 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.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
We gave a short period of notice for the inspection because we wanted to be sure the provider had an Infection Control procedure and Covid 19 risk assessment in place. We did this so we could adhere to their policies and follow government guidelines in relation to social distancing.

What we did before the inspection
We reviewed information we had received about the service since the last inspection as well as recent safeguarding concerns that had been raised. We sought feedback from the local authority and other professionals who worked with the service. We used all of this information to plan our inspection.

The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service

does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During the inspection
We spoke with one person using the service and two family members during the site visit on 10 August 2020. We also contacted five family members by telephone on the same day. We had discussions with six staff that included the registered manager and five care and support staff.

We reviewed a range of records. These included six people's care records and risk assessments. We looked at four staff files in relation to recruitment, training and staff supervision. A variety of records relating to the management of the service including quality assurance checks, staff rotas, safeguarding information and accident and incident information.

Inspected but not rated

Is the service safe?

Our findings

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

This is the first inspection for this newly registered service. This key question has been inspected, but not rated.

This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Using medicines safely

● Temperature records for medicines fridges showed that the fridges had not been operating at the optimum temperature. Although checks had identified this, no action had been taken.

● We found one error in relation to the stock balance of one controlled medicine to be returned to the pharmacy. We discussed this with a senior staff member and found it was a recording error.

● The controlled medicines records showed several crossing outs which was not in line with best practice. This demonstrated that staff were not familiar with best practice guidance when dealing with controlled medicines and may put people at risk.

● We found an over the counter medicine that was unlabelled and there was no record of the medicine recorded on the persons Medication Administration Records (MAR) charts. This put people at risk of receiving un-prescribed medicines with no safeguards in place to ensure they were administered safely.

● Handwritten entries on the MAR charts did not follow best practice guidelines. For example, we found two charts that did not record the tablet strength, quantity to be given and they were not dated or signed by two staff to reduce the risk of error. This put people at risk of receiving the incorrect dose of prescribed medicines.

Assessing risk, safety monitoring and management

● There were risk management plans in place to keep people safe, however records did not always demonstrate that these had been reviewed regularly, for example the risk assessment for one person assessed as being at very high risk of developing a pressure sore had been reviewed once since February 2020. This meant there was an increased risk to the person of pressure area damage.

● We observed inconsistent approaches by staff when they were supporting people to manage their behaviours. For example, one person became anxious and wanted to go home. Two staff used different approaches when trying to support the person to reduce their anxieties. This was not consistent with the information in their care plan.

● Some areas of identified risk did not have supporting risk assessments in place to keep people safe. For example, it had been identified that one person often woke in the night, wandered with purpose and could become fretful and distressed. There was no risk assessment or behaviour support plan in place on how to support the person to stay safe.

● For one person who needed support to manage their behaviours there was no guidance about how staff needed to support the them to stay safe when they self-harmed and no information about how to keep others safe when the person became anxious and needed support to manage their behaviours. This placed

people at risk of inappropriate and inconsistent care and support when being supported to manage their behaviours.

● Care plans for people with significant health needs such as heart/kidney failure lacked specific information in relation signs and symptoms for these conditions. There was no guidance or risk assessments in place for staff to know when to seek medical advice. This placed people at potential risk of deterioration in their physical health.

● People's risk assessments had not been reviewed and updated following incidents where people had fallen. This put people at risk of recurrent falls because strategies to prevent further falls and reduce the chance of injury were not identified as part of an on-going review processes.

The provider failed to assess the risks to the health and safety of people and do all that is reasonably practicable to mitigate any risks. The provider had failed to ensure the management of medicines was robust so that people received their medicines as prescribed. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

● We received mixed views about staffing levels at the service. Some feedback we received from family members and staff was that there was a shortage of staff at weekends. Others did not express any concerns in relation to staffing. Rotas showed that staffing levels were consistent.

● One person using the service told us they were having problems receiving their medicines at the right time. They said they preferred to have them when they got out of bed but often didn't receive them until 10:30am and felt this was because staff were too busy.

● A visiting health professionals' feedback via a satisfaction survey said that they often found it hard to find a staff member to 'discuss the care of my patients' and that staff often 'appeared stressed'.

● Staff rotas showed that staff often worked long days consisting of 14-hour shifts. This had led to one staff making a mistake with people's medicines because they were tired.

● On the day of our visit we found that people's call bells were answered swiftly, and people did not have to wait long until staff attended to their needs.

● The provider followed robust recruitment procedures to ensure people were protected from staff that may not be fit to support them. The Disclosure and Barring Service (DBS) security checks and references were obtained before new staff started the probationary period. These checks help employers to make safer recruitment decisions and prevent unsuitable staff being employed.

Systems and processes to safeguard people from the risk of abuse

● People and relatives told us Five Rivers Living was a safe place to live. One relative said, "The safety is great, if anything happens, I get a phone call." Another commented, "[Family member] is getting very frail but they have not had any falls or problems that I am aware of. [Family member] seems to be as safe as possible."

● Most staff confirmed they had completed safeguarding training. One member of staff told us they hadn't completed the training yet because they were new to the service. The records for another staff member showed they had not completed safeguarding training.

● Although staff had an understanding of what safeguarding was and the different types of abuse, two staff we spoke with did not understand the term 'whistleblowing.' This did not assure us that staff understood the process of how to report concerns to the relevant people.

● The provider had policies and procedures to keep people safe. The registered manager was aware of their responsibility for making safeguarding referrals and reporting concerns to the Care Quality Commission (CQC). Records showed that these were completed.

Learning lessons when things go wrong

● The systems in place to learn from accidents, incidents and safeguarding concerns needed to be strengthened.

● Peoples risk assessments and care plans had not been reviewed and updated following incidents where people needed to be supported with their behaviours. We saw that staff recorded behaviour incidents on ABC behaviour charts, however these had not been reviewed to identify themes and trends. This meant the lack of investigation and analysis of incidents failed to ensure lessons were learnt and improvements made to people's care.

Preventing and controlling infection

● People and relatives told us the home was kept clean and hygienic. We observed this to be the case on the day of our visit.

● Measures were in place to control and prevent the spread of infection. Staff completed training and were knowledgeable about the requirements.

● We observed staff using personal, protective clothing and equipment safely.

● We observed a COVID 19 risk assessment and audit and cleaning plans in place.

Inspected but not rated

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

This is the first inspection for this newly registered service. This key question has been inspected, but not rated.

This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

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

- Quality monitoring checks in place to assess, monitor and improve the overall quality of the service were not always effective at identifying areas that required improvements. For example, they had not identified issues with medication and risk assessments.
- The provider did not undertake any additional governance checks to allow them to monitor the service and take actions where improvements were needed. There was a clear lack of provider oversight to ensure systems in place were being followed and to ensure the registered manager was fully supported in her role.
- The registered manager confirmed they did not use a dependency tool to regularly assess people's needs and determine staffing numbers. The registered manger told us they were always, 'over staffed' but it is not certain how she was able to determine this.
- Most staff had completed mandatory training. However, we found that some training needed to be more specific to the people staff supported, for example positive behaviour management and catheter care. The training needed to be appropriate for staff to understand due to language barriers.
- There was no staff training matrix in place so we could assess all staff training. The registered manager said it was on her action plan but hadn't completed it at the time of our visit. We were not assured that the registered manager had an effective oversight of staff training and staff competencies.
- Care plans for people with significant health needs lacked information in relation to their specific condition. This put people at risk of receiving care and support that did not meet their individual health needs.

The provider failed to ensure systems and processes were in place to assess, monitor and improve the service. This was a breach of Regulation 17, (good governance), of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- There was a registered manager in post. She told us she worked long hours and said she was trying to recruit a deputy manager to support her in her role. One person told us, "I feel she [registered manager] needs more support, then if she hasn't got time to talk you can always go to the other manager."

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

● People and relatives said Five Rivers Living was a nice place to live and the registered manager was open and approachable. One relative said, "I spoke to the manager before [family member] went in and on the day the she came out and spoke to us for quite a long time. She really reassured me that we have chosen the right place." Another relative told us, "The manager is quite brilliant. She knows what she is doing."
● The registered manager knew all the people using the service well and told us she spoke with them regularly to get their views on the care provided. A person said, "I was asked if I wanted to help with interviewing staff, I've given a bit of input in the past."
● Staff spoke positively about the leadership and management of the service. Staff felt well supported and able to approach the registered manager with any feedback about the care or quality of the service and felt this would be listened to.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● The provider had reported concerns in relation to COVID 19 to families and the local authority in a timely manner to enable appropriate, additional support to be provided if needed.
● The registered manager told us they understood, and would act on, their duty of candour responsibility. We saw that incidents had been shared with family members.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● The provider had systems in place to obtain feedback from people using the service, relatives, visiting healthcare professionals and staff. One relative told us, "I have filled in a questionnaire about the home. It asked for my views."
● Staff told us that communication throughout the service was good. They felt well supported and said they had opportunities to contribute their views to the running of the service through staff supervisions and staff meetings. There were daily handover meetings where staff discussed anything of note and made sure they always had up to date information

Working in partnership with others
● Staff worked in partnership with other health and social care professionals sharing information and assessments where appropriate.
● The registered manager had worked closely with the local authority during the pandemic to ensure all guidance about Covid 19 was up to date and in line with best practice. They had also liaised with Public Health England to ensure they were following current Government guidelines.

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 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to assess the risks to the health and safety of people and do all that is reasonably practicable to mitigate any risks. The provider had failed to ensure the management of medicines was robust so that people received their medicines as prescribed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to ensure systems and processes were in place to assess, monitor and improve the service.