Dentak Care and Services Limited

# The Riverside Nursing Home

## Inspection report

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16 May 2018

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## Ratings

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|---|---|
| Overall rating for this service | Requires Improvement |

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|---|---|
| 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? | **Requires Improvement** |

# Summary of findings

## Overall summary

We inspected The Riverside Nursing Home on the 9 and 16 May 2018. The first day of the inspection was unannounced. The Riverside Nursing Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided and both were looked at during this inspection.

The Riverside Nursing Home is a detached two-storey converted and extended building situated in the centre of the village of Littleborough, close to shops, local amenities and public transport. It has a car park to the front of the home which can accommodate up to eight cars. At the back of the home there is a small enclosed patio area.

The Riverside Nursing Home is registered to care for up to 25 older people, caring mainly for people living with dementia. There were 18 people using the service at the time of the inspection.

We last inspected The Riverside Nursing Home on 16 and 17 August 2017. During that inspection we found there were six breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These were in relation to; unsafe and unclean premises, the privacy and dignity of people who used the service was compromised, suitable and sufficient activities and community involvement were not provided and there was no staff training in caring for people living with dementia.

Following the last inspection of 16 and 17 August 2017 we asked the provider to take action to make improvements. The provider sent us an action plan informing us that they had taken action to ensure the regulations had been met.

Following the last inspection of 16 and 17 August 2017 we also took enforcement action in respect of the provider failing to comply with Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 20014 (an ineffective system in place to assess, monitor and improve the quality and safety of the service and records necessary for the management of the home were either not in place or were not accurate). A Warning Notice was served on the registered provider requiring them to comply with the relevant regulations within 14 days from the date of the Warning Notice. During this inspection we found that the provider had complied with the requirements of the Warning Notice.

The service was also placed into Special Measures following the last inspection which meant it was kept under regular review and inspected within six months of the last inspection report being published. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

During this inspection we found there had been a significant improvement and the provider had met some of the previously breached regulations. Due to the improvements seen on this inspection the provider has

been taken out of Special Measures.

Although we found that improvements had been made we found further breaches of the Health and Social Care Act 2008 (Regulated-Activities) Regulations 2014. We found there had been a significant improvement in the safety and cleanliness of the environment. Fire exits remained free of obstruction, restrictors had been fitted to most of the windows, most wardrobes were now secured to the wall, the patio areas were litter free and a lock had been fitted to the laundry door. We also saw that most, but not all, of the broken furniture had been repaired or removed. We found however that some safety issues still needed to be addressed, such as; not all wardrobes were secured to the wall, there remained one unguarded radiator and one window remained without a restrictor.

We also found the following; the provider was not compliant with the legal requirements of the Mental Capacity Act 2005 (MCA), there was no risk assessment in place for a person at risk of choking, no pressure ulcer prevention plan for a person at risk of developing pressure ulcers and a lack of suitable and sufficient activities for people, particularly for people living with dementia.

The home did not have a registered manager. 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 of the Health and Social Care Act 2008 and associated Regulations about how the service is run. The home had appointed a manager who had been in post for approximately four months. We are aware that the manager had submitted their application to the CQC to become the registered manager.

Where regulations have been breached information regarding these breaches is at the back of this report.

To improve the care and support for people living with dementia we have recommended that the provider seeks out links with specialist dementia services who can give practical guidance and advice. This was because the environment, equipment and activities provided for people living with dementia were not adequate.

Although staff had received training in caring for people living with dementia their understanding of the types of dementia and how best to care for people living with dementia was limited. We have recommended that more in depth training be provided.

We have recommended that further improvements need to be made to the auditing of the service to ensure that a more effective quality assurance system is in place.

We received mixed comments about the staffing levels within the home although we found that people were adequately supervised and care was provided in a calm and unhurried way. We have recommended that the staffing levels are kept under constant review.

We found that staff did not always consider the need to preserve people's dignity. One person had been left in an undignified situation in relation to their sleeping arrangements and some bedroom doors remained without locks.

People told us they enjoyed their meals and we saw that they were provided with a choice of suitable and nutritious food and drink to ensure their health care needs were met. We found however that there was no encouragement to promote meal times as a pleasant, social occasion. There were no menus for people to look at and the tables had no place settings or tablecloths. We have recommended that the meal time

experience be improved and have also recommended that snacks, fruit and 'finger food' be left out for people to eat and enjoy when they wish.

People told us they received the care they needed when they needed it and were free to make everyday choices. They told us they considered staff were kind, had a caring attitude and felt they had the right skills and knowledge to care for them safely and properly. We found people were cared for by staff who were safely recruited and regularly supervised.

Suitable arrangements were in place to help safeguard people from abuse. Staff knew what to do if an allegation of abuse was made to them or if they suspected that abuse had occurred.

The medication system was safe and we saw how the staff worked in cooperation with other healthcare professionals to ensure that people received appropriate care and treatment.

Specialised training was provided to help ensure that staff were able to care for people who were very ill and needed 'end of life' care.

All areas of the home were clean and procedures were in place to prevent and control the spread of infection. Records showed that equipment and services within the home had been serviced and maintained in accordance with the manufacturers' instructions.

Procedures were in place to deal with any emergency that could affect the provision of care, such as a failure of the electricity or gas supply.

Records we looked at showed there was a system in place for recording complaints and any action taken to remedy the concerns raised. Records showed that any accidents and incidents that occurred were recorded and monitored.

## 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.

The provider had failed to ensure that all areas of the premises were kept safe.

There was no risk assessment in place for a person who was at risk of choking.

People were given their medicines safely and as prescribed.

### Is the service effective?

**Requires Improvement**

The service was not always effective.

The provider was not compliant with the legal requirements of the Mental Capacity Act 2005 (MCA).

There was no specialist provision in place to care for and support people living with dementia. Also more in depth training in caring for people living with dementia needs to be provided for the staff.

People were provided with sufficient food and drink to ensure their health care needs were met; however there was no encouragement to promote meal times as a pleasant, social occasion.

### Is the service caring?

**Requires Improvement**

The service was not always caring.

We found that staff did not always consider the need to preserve people's dignity.

People spoke positively of the kindness and caring attitude of the staff.

### Is the service responsive?

**Requires Improvement**

The service was not always responsive.

People's care records did not always contain enough information to guide staff on the identified care and support required.

There were no established links with community organisations to either support alternative social networks or provide opportunities for a range of different activities for the people who used the service.

Specialised training was provided to help ensure that staff were able to care for people who were very ill and needed 'end of life' care.

Suitable arrangements were in place for reporting and responding to any complaints.

## Is the service well-led?

**Requires Improvement**

The service was not always well-led.

The service did not have manager who was registered with the CQC.

Further improvements need to be made to the auditing of the service to ensure that a more effective quality assurance system is in place.

Accidents or incidents that CQC needed to be informed about had been notified to us by the manager.

# The Riverside Nursing 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 checked 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 was a comprehensive inspection which took place on 9 and 16 May 2018. The first day of the inspection was unannounced.

The inspection was undertaken by two adult social care inspectors and an expert by experience on the first day and three adult social care inspectors on the second day. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to the inspection we also looked at the previous inspection report and information we held about the service and provider, including notifications the provider had sent to us. A notification is information about important events that the provider is required to send us by law.

We contacted the local authority professionals who were responsible for organising and commissioning the service on behalf of individuals and their families. In addition we contacted the Infection Prevention & Control Officer who had recently inspected the home. Feedback received is included in the Safe and Well-led section of this report.

As some of the people living at The Riverside Nursing Home were not able to tell us about their experiences, we undertook a Short Observation Framework for Inspection (SOFI) observation. A SOFI is a specific way of observing care to help us understand the experience of people who are not able to talk with us.

During the inspection we spoke with eleven people who used the service, three visitors, the manager, the

business manager, one of the registered nurses, five care assistants, the cook, the laundry assistant and the cleaner.

We looked around all areas of the home, looked at food provision, six people's care records, ten care monitoring records, six medicine administration records and the medicine management system, seven staff recruitment files, training records and records about the management of the home.

Requires Improvement

# Is the service safe?

## Our findings

People who used the service told us they felt safe. Comments made included; "Yes I feel safe. I have no worries about anybody," "I feel safe here and the people are wonderful" and "I feel safe from the staff, yes." Relatives we spoke with told us; "My [relative] is safe here" and "Yes it is safe."

Inspection of care records showed that risks to people's health and well-being had been identified, such as poor nutrition, falls and the risk of developing pressure ulcers. We saw care plans had been put into place to help reduce or eliminate the identified risks. We did identify from one of the care records however that the person was at risk of choking. Although there was some information about the person being at risk, there was insufficient information in place to inform staff on how to reduce or eliminate the risk of choking. We found this was a breach of Regulation 12 (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at all areas of the home. There was a keypad lock at the front door and also on the door from the entrance hall into the home. This helped to keep people safe by ensuring the risk of entry into the building by unauthorised persons was reduced. It also helped to prevent people who were assessed as being at risk if they left the home alone, from leaving the building unsupervised.

During the last inspection of 16 and 17 August 2017 we found the provider had failed to ensure the premises were kept clean and safe. Fire exits had been obstructed, window restrictors were missing on several windows above ground floor level, several wardrobes were not secured to the wall, broken furniture was in place in some bedrooms, lighting in a corridor was poor, the patio areas of the home were littered with rubbish and there was no lock on the laundry door.

During this inspection we found there had been a significant improvement in the safety and cleanliness of the environment. Fire exits remained free of obstruction, restrictors had been fitted to most of the windows, most wardrobes were now secured to the wall, the patio areas were litter free and a lock had been fitted to the laundry door. We also saw that most, but not all, of the broken furniture had been repaired or removed.

We found however, that the following safety issues still needed attention; four bedrooms had wardrobes in place that were not secured to the wall, one bedroom had an unguarded radiator and one bedroom had a window without a restrictor. Unguarded radiators, unsecured wardrobes and the lack of a restrictor to the window placed people at risk of harm. The business manager told us that the wardrobes and radiator cover had probably been removed during the redecoration programme. We were told that the issues would be addressed as a matter of urgency.

Failing to ensure that the premises are safe is a continuing breach of Regulation 12 (2) (d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the inspection we received an email informing us that the wardrobes had been secured, the window restrictor and the radiator cover had been fitted.

We also found there was, once again, no lighting in one of the corridors. Although the light bulb was replaced whilst we were at the home we were told during the last inspection that the light bulb fused regularly. For the safety of people who live, work and visit the home adequate lighting must be provided. Action must be taken to ensure that any fault in the electrical light point is addressed.

We also found that the cellar room door did not have a lock on it. The door opened on to a steep staircase leading down to the cellar. The area was accessible to people living at the home and placed them at risk of harm. When we discussed our concerns with the provider they arranged for a lock to be fitted to the door and it was fitted whilst we were present in the home.

Outside on the patio we saw there were some steep steps that led to a basement area. The steps were not enclosed and posed a risk to the safety of the people who used the service. We were told that people would never be left unsupervised in that area but the provider agreed it would be safer to enclose the steps. We saw that work was being undertaken to enclose the steps whilst we were present in the home.

We saw that the majority of the bedrooms did not have a call bell lead or a bedside light. We were told by the provider this was because the people who occupied the rooms were not able to call for assistance and did not use a bedside light.

We have recommended that the manager conduct a full review of all call bells and bedside lights to ensure that people who are able, can have the use of a bedside light and also access help and support should they need it. Call bells can also be used by staff if they require assistance whilst in someone's bedroom, so this should also be taken into account in the review. The outcome of the assessments must be recorded in people's care records.

On several occasions throughout both days of the inspection we heard a loud droning noise. The provider told us they thought it was something to do with air in the water pipes as the noise happened when the water was being drawn. This was very noticeable and distracting. We told the provider that this needed to be addressed as soon as possible. Following the inspection we received an email informing us that work had been carried out on the water tank and the problem had been resolved.

We looked at the on-site laundry facilities situated on the ground floor. We saw there had been an improvement in how the laundry room had been organised. The room had been divided so that clean and dirty laundry was not stored in the same area. This helps to prevent cross contamination and reduces the risk of cross infection. We found there was sufficient laundry equipment to ensure effective laundering. Hand-washing facilities and protective clothing of gloves and aprons were in place. To minimise the risk of staff handling heavily soiled laundry, the laundry was placed in special bags that disintegrated when placed in very hot water in the washing machine.

During the last inspection of 16 and 17 August 2017 we found that clinical waste was not disposed of safely and there was a breach of Regulation 12 (2) (h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. During this inspection we found the service had complied with the Regulation.

Prior to the inspection we contacted the Infection Prevention and Control Nurse from Rochdale Council. This was to seek their views on what progress they felt the service had made following their recent infection control audit. We were told that improvements had been made; especially with the provision of the two new sluices that had been installed to ensure the safe handling and disposal of waste.

We saw infection prevention and control policies and procedures were in place and the majority of the staff

had been trained in infection prevention and control.

Staff we spoke with understood the importance of infection control measures, such as the use of colour coded cleaning equipment and the use of personal protective equipment when handling food, completing personal care tasks and cleaning.

We saw staff wore protective clothing of disposable gloves and aprons when carrying out personal care duties. Alcohol hand-gels and hand-wash sinks with liquid soap and paper towels were available throughout the home. Good hand hygiene helps prevent the spread of infection and wearing protective clothing helps protect staff and people who use the service from the risk of cross infection during the delivery of care.

We looked to see what systems were in place in the event of an emergency. We saw personal emergency evacuation plans (PEEPs) had been developed for all the people who used the service. These were kept in a central file in the manager's office; ensuring they were easily accessible in the event of an emergency. We saw they were reviewed regularly to ensure the information was accurate and up to date.

We also saw the procedures that were in place for dealing with any emergencies that could arise, such as flooding, utility failures and other emergencies that could affect the provision of care.

Inspection of records showed that an up to date fire risk assessment was in place and regular checks had been carried out to ensure the fire exits were kept clear and confirm that the fire alarm, emergency lighting and fire extinguishers were in good working order.

Records showed that equipment and services within the home were serviced and maintained in accordance with the manufacturers' instructions. This included checks in areas such as gas safety, risk of legionella disease, portable appliance testing, fire detection, the lift and lifting equipment. This helps to ensure the safety and well-being of everybody living, working and visiting the home.

During the last inspection of 16 and 17 August 2017 we saw that hot water outlet temperatures were checked weekly. We asked to see the most recent checks during this inspection but the records were not available. The provider was required to send the information to us following the inspection, which they did. The information showed that regular water temperature checks were undertaken. Checking water temperatures helps to keep people safe from harm.

We found the staff recruitment system was safe. We looked at seven staff personnel files to check if appropriate checks had been made when recruiting new staff. Records contained proof of identity, an application form that documented a full employment history, a job description and references.

Checks had also been carried out with the Disclosure and Barring Service (DBS) before the member of staff began work. The DBS identifies any people who are barred from working with children and vulnerable adults and informs the service provider of any criminal convictions noted against the applicant. This meant that checks had been completed to reduce the risk of unsuitable staff being employed at The Riverside Nursing Home.

We saw the provider had checked that the registered nurses who worked at the home had a current registration with the Nursing and Midwifery Council (NMC).

Policies and procedures for safeguarding people from harm were in place. These provided staff with guidance on identifying and responding to signs and allegations of abuse. Staff told us they would feel

confident to report any poor practice they might see. Comments made included; "I would report it straightaway", "It is important to protect vulnerable people and I would report it to the manager" and "It's about protecting people and I would report it."

One staff member told us they knew that safeguarding was about, "Keeping vulnerable people safe" but they were unsure about the reporting procedure. They explained that they had not had any safeguarding training but knew that it had been arranged for the following week.

The training records we looked at showed that the staff had not received any recently updated training in safeguarding adults and children. Information displayed on the office notice board showed that the training had been arranged for two dates during the month of May 2018. Following the inspection we received an email informing us that staff had undertaken Safeguarding Adults and Children training on 21 and 22 May 2018.

We had been made aware that three safeguarding incidents were under investigation by the Rochdale Safeguarding Team. Notifications sent to us, and records within the home, showed that the provider had correctly followed the safeguarding process.

We looked at the systems in place for managing medicines within the home. This included the receipt, storage, handling, recording and disposal of medicines. We found that medicines were stored securely and there was a safe system in place for the disposal of medicines no longer required. There was a controlled drug cabinet and a controlled drug register in place to ensure the correct storage and recording of controlled drugs.

We checked the medicine administration records (MARs) of six people who used the service. The MARs showed that people were given their medicines safely and as prescribed; ensuring their health and well-being were protected. There was guidance in place for the medicines that were to be given 'when required' or as a 'variable dose' of one or two tablets. Guidance needs to be in place for staff to follow in order to ensure that medicines are given in accordance with a person's need and preference.

We received mixed comments about the staffing levels within the home. Comments made included; "Some days staffing levels can be low, but most times there are plenty of staff around," "The staffing levels could be better, especially at busy times" and "There is no chef after two o'clock and the carers have to cook. It leaves them short staffed."

Throughout the inspection we found that people were adequately supervised and that care and support was provided in a calm and unhurried way.

The manager told us they felt there were enough staff on duty to meet the needs of the 18 people who used the service. The home operated with four care staff and one registered nurse throughout the daytime hours of 8am to 2pm, with one extra care staff on duty normally between the hours of 8am to 2pm, to deliver 1-1 care to a person. From 2pm to 8pm there was one registered nurse and three care staff. During the hours of 8pm to 8am the home operated with one registered nurse and two care staff. The care staff were supported by domestic and catering staff who worked from 8am to 2pm.

We did discuss with the manager and the provider, in view of the comments made, that there was a need to keep the staffing levels under review.

The staffing rota identified that the manager had some supernumerary hours to undertake management

duties. In addition the business manager worked variable hours to support the manager and to also deal with non- clinical management issues.

During the last inspection of 16 and 17 August 2017 we were told that the staffing hours were determined according to the support needs of people who used the service. However, there was no formal process for identifying the level of staffing needed. We recommended that a formal process be implemented so that the staffing levels were based on an accurate and current assessment of people's needs.

During this inspection we were shown the assessment tool that was in use to determine the level of staff required. Whilst it was a detailed document that showed the care staff hours needed for a specific level of care required, the provider had not undertaken an assessment of each person who used the service to determine their dependency level. We discussed this with the provider who informed us that the dependency assessments would be undertaken as soon as practicable.

Requires Improvement

# Is the service effective?

## Our findings

People we spoke with told us they received the care they required when they needed it. Comments made included; "They have got it just about right," "They know what they are doing" and "They are well trained to do what is needed."

We looked at what consideration the provider gave to 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.

We looked at three care records and found that the MCA assessments were not always dated, were not decision specific and showed no evidence that people's views, wishes and beliefs had been considered. The MCA is clear that we should not assume that people lack capacity and that we need to ensure that people's views, both past and present, are considered. Further consideration should be given to how the service can maximise people's independence to ensure that the approach is both respectful of people's rights and in keeping with the least restrictive principle specified by the Code of Practice. The approach also needs to keep each person's assessment under active review as a person's mental capacity can fluctuate.

We saw that one person who used the service was in receipt of covert medication (this is where medication is given in their food and/ or drink without the person's knowledge). Although there had been an authorisation from the person's GP to administer their medicine in this way, there was no evidence that a 'best interest meeting' had been undertaken. A 'best interest' meeting is where other professionals, and family if relevant, decide the best course of action to take to ensure the best outcome for the person using the service.

We found that the service was not working within the principles of the MCA and that it was not compliant with the legal requirements of the MCA. This was a breach of Regulation 11(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We found that initially the manager was not aware of how many people had an authorised DoLS in place. The manager was also unaware of what conditions people were subjected to. Following a review of the care records the manager was able to ascertain that 16 people had an authorised DoLS. We suggested to the manager that it would be good practice to have a central file in place to ensure a good oversight. This was in addition to the information being in each person's care records.

The Riverside Nursing Home is registered to accommodate up to 25 people, and states it provides care for

people living with dementia. Bedrooms are provided on the ground and first floor and accessible by a passenger lift.

We found that no specialist provision was in place to care for and support people living with dementia. There was a lack of suitable aids and adaptations for people living with dementia. The toilet seats and grabs rails in the bathrooms and toilets were not of a different colour than the toilet. Research has shown that coloured seats and grab rails assist people living with dementia to recognise the toilet more easily. We did see that the bathrooms and toilets had pictorial signs on the doors to assist identification of the facilities.

During the last inspection of 16 and 17 August 2017 we found there was a lack of signage in the home. The bedrooms had numbers on the doors but no names or photographs of the person whose room it was. During this inspection we found there had been some improvement as people's names and photograph had been affixed to their bedroom door. Having their names and/or photographs on the doors aids people's recognition of their room and helps with their independence and autonomy.

We saw however that people's bedrooms had not been furnished with 'dementia friendly' furniture. To assist people recognising where their clothes are, wardrobe doors should be fitted with a transparent section. The same feature should also be available on the sets of drawers.

There was a lack of specialised calendars and clocks to help people living with dementia to tell the time and help with their orientation. Although there were pictures on the walls in bedrooms, corridors and the lounges they were not pictures that would aid reminiscence and generate areas of conversation.

'Dementia friendly' equipment needs to be in place to help promote the well-being of people living with dementia. It helps people to retain their independence and reduce any feelings of confusion and anxiety.

We have recommended that the provider seeks out links with specialist dementia services such as the Alzheimer's Society or the Admiral Nurses. The Admiral Nurses are specialist dementia nurses who give expert practical, clinical and emotional support and guidance to families and to staff caring for people with dementia.

We saw that a corner area of the front lounge/ dining room was cordoned off with a hospital screen. Behind the screen various pieces of equipment were being stored. Apart from looking unsightly it restricted the amount of lounge space for people. We asked the provider to move the stored items to a more acceptable place. The provider told us they had limited storage space but they would look into removing the equipment.

We saw that people who wanted to move around the lounge and dining room independently were not restricted from doing so. We did see however that there were keypad locks on the two doors that led onto the corridors where two bedrooms were situated. Having these two doors kept locked restricted the free movement of the people who lived in those two rooms. The provider agreed to have the keypad locks removed and informed us by email following the inspection, that they had been removed.

The Riverside Nursing Home does not have a front or back garden. It has a parking area to the front of the home and a secure, south facing enclosed patio to the rear of the home that overlooks a river. During the last inspection of 16 and 17 August 2017 we were made aware that people who used the service did not have access to the rear patio. During this inspection we saw that garden furniture had been provided and people who used the service were able to sit outside and enjoy the sunshine and fresh air.

We looked to see if people were provided with sufficient food and drink to ensure their health care needs were met. On the first day of the inspection we found that food stocks were low and the cook was not able to provide the meal that was detailed on the menu. Despite food stocks being low people did receive sufficient food and drink. There was however no fresh fruit available. We were informed that food was to be delivered the following day.

On the second day of the inspection we saw there was a good stock of fresh, frozen and dry food. There was a four week rotating menu in place with a choice of meal for lunch and tea. The menus did not show what people could have for their breakfast or for their supper. We have recommended that these are added to the menu. We saw that the day's menu was written on a wipe board and this was not easily visible for some people. There were no pictorial menus to help people living with dementia to express their choice of meal. We have recommended that pictorial menus are provided.

The main meal was served at lunch time and a lighter meal was served in the evening. The cook told us that the kitchen was always open and food was available 'out of hours'. We saw there were no snacks or fruit in the lounges for people to help themselves. We asked some of the care staff to tell us how they ensured that people were given fresh fruit. We were told that fruit was cut into small pieces and given out to those people who wanted it during the mid-morning and mid-afternoon drink rounds. We were also told that people could have fruit at other times if they requested it.

A discussion with the cook showed they had not received any specific training in relation to special diets but nevertheless they were knowledgeable about any special diets that people needed. The cook was also aware of how to fortify foods by the addition of dried milk, butter and/or cream to help improve a person's nutrition.

For some people living with advanced dementia they find it hard to identify food on white plates. We asked the provider to consider providing coloured plates for people so food could be more easily recognised.

We observed lunch being served in the dining room. There were 12 people sat in the dining room; the other four people stayed in the lounge and ate at small tables. The dining tables looked bare; they were without tablecloths and napkins and we felt this gave an institutional feel. We asked the provider to consider making the tables look more inviting and promote meal times as a pleasant, social occasion. We saw that hot and cold drinks were served with the meal and throughout the day.

Four people required assistance with eating their meals and we saw that staff were patient and discreet when assisting them.

One relative, without any prompting told us, "The meal looks nice." Other comments included; "I like it," "Perfect," "The food is very nice and very good and I enjoy eating it. That makes a difference" and "We have different choices every day."

The care records we looked at showed that people were weighed regularly, had an eating and drinking care plan and were assessed in relation to the risk of inadequate nutrition and hydration. We saw action was taken, such as a referral to the dietician or to their GP, if a risk, such as an unexplained weight loss, was identified.

The care records also showed that people had access to external health and social care professionals, such hospital consultants, social workers, opticians, chiropodists and dentists.

We looked to see how staff were supported to develop their knowledge and skills. During the last inspection of 16 and 17 August 2017 we found there was a breach of Regulation 18 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the majority of staff had not received training in dementia care. In view of the fact that the majority of people who used the service were living with dementia this was not sufficient to ensure people's needs were met. During this inspection we found that whilst most of the staff had undertaken a form of dementia training their understanding of the types of dementia and how best to care for people was limited. We discussed with the provider the need for more in depth training to be provided.

Inspection of the training plan showed that the necessary training to enable staff to do their job safely had been done. Comments made by staff included; "Training is a big thing since the new manager started."

We asked the manager to tell us about the induction programme that was in place for new staff. We were shown the induction programme that all newly employed staff had to undertake when they first started to work at the home. It contained basic information in the form of a 'check list' to help them understand what was expected of them and what needed to be done to ensure the safety of the staff and the people using the service. There was no information to prepare staff for their role, such as values, behaviours, codes of conduct and aims and objectives.

The manager told us that the Care Certificate induction programme that we had recommended during the last inspection of 16 and 17 August 2017 was to be used in the future. We were shown the booklets that had been developed for the staff. The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working life. The Care Certificate gives everyone the confidence that workers have the same introductory skills, knowledge and behaviours to provide compassionate, safe, high quality care and support.

Information in the seven personnel files that we looked at showed systems were in place to ensure staff received regular supervision. Supervision meetings help staff discuss their progress and any learning and development needs they may have and also raise good practice ideas. One staff member we spoke with told us, "Yes we have regular supervision."

We asked some of the care staff to tell us how they were kept up to date with people's changing needs. We were told there was a written and verbal 'handover' on each change of shift and that staff were allocated into teams each day.

We asked the manager to tell us how, in the event of a person being transferred to hospital, information about the person was relayed to the receiving service. We were shown the, 'This is Me' document that was sent with the person when they were taken to hospital. We saw the document was kept in each person's care file. The document provided information about the person's needs, health conditions and the care and support required. In addition to the document we were told that a copy of the person's MAR was also sent with them.

Requires Improvement

# Is the service caring?

## Our findings

We asked people who used the service and visiting relatives if they felt the staff were caring. Comments made included; "They are definitely kind, respectful and caring," "They put themselves out to help you," "They are nice people here" and "I have no worries about anybody."

Some of the people living at The Riverside Nursing Home were not able to tell us about their experiences. Therefore we spent some time observing how staff interacted and supported people. We saw that staff were kind, patient and attentive. One staff member dealt very sensitively with a person who had behaviour that challenged. Although the person was able to walk unaided the staff member held their hand when they were walking to reduce the risk of their behaviour impacting on other people.

We found in one person's room there was no divan base and the mattress was on the floor. The provider told us this was to prevent this person from hurting themselves if they rolled out of bed. This was undignified. This person was lacking postural support and could potentially have been sleeping in a draught. To maintain the person's dignity and ensure their safety, we required the provider to address the issue. Whilst we were present in the home a divan bed was made available, the legs of the bed were shortened and protective mats to cushion any possible fall, were placed on the floor at the side of the bed.

During the last inspection of 16 and 17 August 2017 we found that none of the bedroom doors had locks. During this inspection we found that Yale locks had been fitted to three of the bedroom doors for people who required them. The locks were safe as they had been 'deadlocked' so that people could not lock themselves in. Staff we spoke with knew where the 'master key' was kept. People must be asked if they would like a door lock and the provider must continue to fit safety locks to bedroom doors for those people who require them. Having a bedroom door lock helps to protect people's privacy and dignity.

During the last inspection of 16 and 17 August 2017 we found there were no individual washbowls available for people who were not able to sit at the sink or wash themselves. During this inspection we found that washbowls had been provided but they were small and resembled a 'mixing bowl' rather than a washbowl. They were not suitable for people to soak their hands and feet in. We discussed with the manager the need to ensure that care is delivered in a thorough and dignified way and that better facilities for washing people should be provided.

We found several used hairbrushes in a basket in the sluice. It indicated to us they were for communal use. We emphasised the importance of ensuring that people had their own toiletries and grooming products. We asked for them to be removed and the provider told us they had disposed of them.

We asked the manager to tell us how people's religious and cultural needs were met. We were told there was one person resident at the home who was from an ethnic minority community. Staff told us this person spoke very little English but was able to make their needs known to the staff. We were told that the person enjoyed 'English' food and that sometimes their family brought in 'special' meals for them. On asking staff if any books, pictures or films in the person's own language had been provided for them we were told they

had not. Consideration needs to be given to providing these to assist in the person's emotional enjoyment and well- being.

The manager told us that people could choose to go to their own place of worship and also have their own clergy visit them. We were told there was nobody living in the home who wanted any involvement in a place of worship.

Information about how to access advocates was displayed in the reception area of the home. An advocate is a person who represents people independently of any government body. They are able to assist people in many ways; such as, writing letters for them, acting on their behalf at meetings and/or accessing information for them. During our inspection visit we saw advocates were visiting people at the home.

We saw visitors coming and going throughout the day, including meal times. People told us they were always made welcome. We did see however that there was no quiet area for people to sit with their visitor. We were told by staff that people could go to their room if they wished but people rarely did. We saw there was a 'Visitor's Room' on the first floor but this was being used for storage and it looked unsightly. We asked the provider to give some consideration to making this room available both for people's visitors and for visiting professionals.

We saw information about people who used the service was kept confidential. The care records were kept in the medicine room that was kept locked when not in use. The registered nurse told us that the care staff were able to access the records on request. The care staff we spoke with were able to confirm that this information was correct. Other records in relation to the running of the home were kept secure in the manager's office.

Requires Improvement

# Is the service responsive?

## Our findings

We asked people if they felt the staff responded well to their needs. Comments made included; "They know if I am not well and will get the doctor for me," "They look after [relative] well. I am glad [relative] is in this home," and "I am happy with the care offered here."

The provider told us there was no activities coordinator employed by the service. We were told that the care staff undertook activities when they could. On the first day of the inspection we saw one member of staff sitting at a table playing a game with one of the people who used the service. During the second day of the inspection we saw staff were encouraging people to exercise to music. Staff were also organising a party for the Royal Wedding.

We asked people who used the service how they passed their time and if they felt there was enough to do to keep them occupied. Comments made to us included; "Smoking," "Sleeping," "Time hangs here," "We occasionally play bingo," "Play games" and "Sometimes we do walking by the river."

Whilst we were in the home a gentleman visited the home accompanied by their friendly greyhound. We were told he visited every week and that people looked forward to patting and talking with the gentleman and his dog.

We asked some of the staff what they felt would enrich the lives of the people who used the service. We were told; "We need extra funding for day trips out," "More activities" and "The worst thing about the service is the lack of organised outings."

Although there had been some improvement in the activities provided since the last inspection, we found there remained little to support and stimulate people who used the service, especially those people living with dementia. People were mainly sat in chairs asleep or with nothing to do. The television was on in the lounge on one channel and music was playing through the television in another area of the lounge. There was no activity board with pictorial information to inform people of the daily/ weekly plan.

There were no established links with community organisations to either support alternative social networks or provide opportunities for a range of different activities for the people who used the service. Suitable and sufficient activities and community involvement must be provided to help promote people's well-being. Failing to do so is a breach of Regulation 10(2) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they were free to make everyday choices. Comments made included; "I sit where I want and I go to bed when I want to," "They don't make me do anything that I don't want to" and "They let me do more or less what I want."

We looked at three people's care records. We saw that people were assessed before they were admitted to the home to ensure their individual needs could be met. We found two of the care plans in place gave

sufficient detail to guide staff on how to provide support to the people in a way that met their physical needs.

One of the care records however did not provide enough information to ensure the person's welfare was protected. Their care record showed they were to have their blood taken at regular intervals each day to check their blood glucose levels. If a person's blood glucose level is too low or too high their insulin dose may need to be withheld/ reduced or increased to maintain their well-being. Medical or specialist advice may also need to be sought. There was no information in the person's care record to show what the maximum and minimum range of their individual glucose levels should be.

It was also documented in this person's care record that they were at high risk of developing pressure ulcers. There was however no pressure ulcer prevention plan in place to guide staff in the care and support required. We found this was a breach of Regulation 9(3) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The care records had been reviewed regularly. We saw that changes were made to the care plans and risk assessments when people's support needs changed.

We asked the manager to tell us how staff cared for people who were very ill and at the end of their life. We were told about The Palliative Care Education Passport training that had been undertaken by four of the registered nurses, and one of the senior care staff. The training had been developed by the education staff at the local hospice. The programme was developed to assist care homes within the region to deliver quality end of life care. The training accredits the actual care worker rather than the organisation they work for so when staff changed their employment they took their skills, knowledge and accreditation with them. The Palliative Care Education Passport training enables staff to recognise and meet the physical, emotional and spiritual needs of the dying person and their family.

We saw that information was easily accessible and visible in a person's care record when they had a Do Not Attempt Resuscitation (DNAR) in place. This is a legal document that identifies that an informed decision has been taken to withhold cardiopulmonary resuscitation (CPR).

We asked people if they knew how to make a complaint. None of the people we spoke with had made a complaint about their care. They told us however that if they had a problem they would speak to a member of the care staff or to the manager. We were told; "I would go to the boss here to make a complaint," "I would tell the staff," "If I was unhappy I would talk to the Sister in Charge" and "I feel if I need to say anything it is easy for me to say it."

We looked at what information was made available to people and visitors should they wish to raise any complaints or concerns. The complaints procedure was displayed in the reception area and gave clear guidance on how to complain. We saw there was a system in place to receive, handle and respond to any complaints raised.

Requires Improvement

# Is the service well-led?

## Our findings

The home did not have a registered manager in post. 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 of the Health and Social Care Act 2008 and associated Regulations about how the service is run. The home had appointed a manager who had been in post for approximately four months.

During the previous inspection of 16 and 17 August 2017 we found there was a breach of Regulation 17(2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had failed to have an effective system in place to assess, monitor and improve the quality and safety of the service and facilities within the home. They had also failed to have records that were necessary for the management of the home in place.

A Warning Notice was served requiring the provider to put into place a quality monitoring system and also to ensure that records necessary for the management of the home were in place. During this inspection we found there had been some improvement in the way that the service and facilities were assessed and monitored. We also found that records necessary for the management of the home were in place. The Warning Notice had been complied with.

Although there had been an improvement and auditing had been implemented on most aspects of the running the home, we found the auditing was basic and mainly a 'tick box' exercise. When issues had been identified there was not always a record of what action had been taken to address it. We have recommended that further improvements need to be made to evidence that a more effective quality assurance system is in place.

Although significant improvements had been made since the last inspection of 16 and 17 August 2017 we found that systems were not established and operated effectively to ensure compliance with the requirements of the Regulations. We found this was a breach of Regulation 17(1) of the Health and Social Care Act 2008.

Staff told us they had confidence in the new manager. We were told; "The best thing about the home is the new manager. I was very unhappy before she came as nobody knew what they were doing. She has organised it," "The manager has made massive improvements" and "I can see the home improving."

People who used the service and their relatives told us they knew who the manager was. Relatives told us they felt they could approach the manager with any problems they might have. People told us, "The new manager seems alright. She talks to people," "The new manager has improved care here" and "The manager is very approachable."

Information from the Commissioners showed they had concerns in relation to the management of the home. We were made aware that they were undertaking regular visits to the service to check compliance

with the requirements of the previous quality monitoring visits undertaken by their Quality Assurance and Contracts team.

We asked the manager to tell us how they sought feedback from people who used the service to enable them to comment on the service and facilities provided. We were told that questionnaires were sent or given out to people and/or their relatives. We looked at some of the surveys that had been returned in January and May 2018. Overall there was positive feedback and very few negative comments. There was no evidence however to show that the negative comments made had been responded to. We discussed with the provider the need to undertake remedial action when any issues of concern had been raised. Acting on concerns and/or recommendations helps to continually improve the service and address people's needs and wishes.

Records showed that a meeting for people who used the service had taken place in March 2018.This was the first meeting held since the appointment of the new manager. The manager told us it was their intention to hold these meetings every three months. We looked at the minutes of the meeting. The content showed that people were asked for their views on the facilities and services provided.

Records we reviewed showed that monthly staff meetings had taken place since the appointment of the new manager. Staff meetings are a valuable means of motivating staff, keeping them informed of any developments within the service and giving them an opportunity to discuss good practice.

We saw that policies and procedures were in place to inform and guide staff on their practice. They made reference however to the previous legislation that the Commission regulated against and not the current legislation. We discussed with the provider the need to amend the policies and procedures. They told us this would be addressed.

We checked our records before the inspection and saw that accidents or incidents that CQC needed to be informed about had been notified to us by the manager. This meant we were able to see if appropriate action had been taken by management to ensure people were kept safe.

From 01 April 2015 it has been a legal requirement of all services that have been inspected by the CQC and awarded a rating, to display the rating at the premises and on the service's website, if they have one. Ratings must be displayed legibly and conspicuously to enable the public and people who use the service to see them. We saw that the previously awarded rating was displayed conspicuously in the reception area. The service does not have a website.

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<br><br>There was no pressure ulcer prevention plan in place to guide staff in the care and support required for a person who was identified as being at high risk of developing pressure ulcers. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 10 HSCA RA Regulations 2014 Dignity and respect<br><br>People were not provided with sufficient and suitable activities and there was a lack of community involvement. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 11 HSCA RA Regulations 2014 Need for consent<br><br>The service was not working within the principles of the MCA and was not compliant with the legal requirements of the MCA. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>It was identified in a care record that there was insufficient information in place to inform staff on how to reduce or eliminate the risk of choking.<br><br>Several areas of the home were not safe. |

| Regulated activity | Regulation |
| --- | --- |
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>Systems were not established and operated effectively to ensure compliance with the requirements of the Regulations. |