Wellburn Care Homes Limited

Riverhead Hall Residential Care Home

Inspection report

Riverhead
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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Riverhead Hall Residential Care Home is a 'care home' providing personal care for up to 45 older people in one adapted building. At the time of our inspection there were 27 people living at the service.

People's experience of using this service and what we found
Safe infection prevention and control (IPC) practices were not followed. The IPC Team had visited the service prior to our inspection and highlighted IPC practices that required improvement. Our inspection identified some of the same issues. The provider took measures to improve these areas during our inspection.

Risks to people were not always managed effectively. Care plans and risk assessments were not always in place or did not reflect people's current needs. Medicines were not always managed safely. Some people did not receive their medication as prescribed.

Systems in place to monitor the service had not been effective as they had failed to identify and address areas that required improvements. Records were not always accurate and up to date.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

We received positive feedback from people's relatives about the care delivered and the caring nature of staff.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was Good (Published 14 September 2018).

Why we inspected
We undertook this Infection Prevention and Control Inspection to follow up on information received from the Local Authority in relation to a coronavirus outbreak. A decision was made for us to inspect and examine potential risks. We inspected and found there were some concerns with IPC practices, records and the overall management, so we widened the scope of the inspection to a focused inspection which included the key questions of safe and well-led.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection. We looked at infection

prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to coronavirus and other infection outbreaks effectively.

The overall rating for the service has changed from good to requires improvement. This is based on the findings at this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Riverhead Hall Residential Care Home on our website at www.cqc.org.uk

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 discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to safe care and treatment and good governance at this inspection. Please see the action we have told the provider to take at the end of this report.

Since the last inspection we recognised that the provider had failed to notify CQC of serious injuries and allegations of abuse. This was a breach of regulation. Full information about CQC's regulatory response to this is added to reports after any representations and appeals have been concluded.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will 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?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Riverhead Hall Residential Care Home

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 and provided a rating for the service under the Care Act 2014.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
This inspection was carried out by three inspectors. Two inspectors completed the site visits and one inspector reviewed documents off site and contacted relatives and staff for their feedback about the service.

Service and service type
Riverhead Hall 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
The first day of inspection was announced and the second day was unannounced.

What we did before the inspection

We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. 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. We used all of this information to plan our inspection.

During the inspection
We spoke with four members of staff on site including, the registered manager, deputy manager and two care workers. We made telephone calls to eight staff and seven relatives. We reviewed a range of records including, four people's care records and multiple medication records. We looked at two staff files in relation to recruitment. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records.

Requires Improvement

Is the service safe?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. 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.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

- Risk assessments were not always in place when people were at increased risks due to their individualised needs. For example, one person had numerous falls, but no risk assessment was in place.
- Monitoring was not in place or ineffective for risks associated to people's health. For example, some people's fluid intake and/or urine output required monitoring. Records were not always in place or consistently completed. This made it difficult for staff to effectively identify concerns and/or deterioration to enable them to seek appropriate support.
- Care plans were not always accurate or reflective of people's current needs. For example, one person's needs had significantly changed. The care records had not been updated at the time of our inspection to reflect their current needs.
- Incidents were not always effectively managed to reduce risks to people. For example, incidents had occurred and although management had reviewed these, they had failed to up to date care records and accurately report to external agencies to ensure measures were taken to mitigate future risk.

The provider had failed to effectively assess, review and manage risk to people's safety. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

- People did not always receive their medicines at prescribed. For example, one person had a pain relief patch that should be changed weekly. This had not been changed until a week later. Another person had not received one of their tablets on four occasions.
- Times of administration of medicines were not always recorded. For example, medicines that were recommended to be taken at the same time each day or needed specific amounts of times between doses.
- Protocols were not always in place for as and when required medication. Protocols in place did not contain sufficient person-centred information to guide staff on when these medications should be administered.

The provider had not ensured the proper and safe management of medicines. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection

● The provider had not ensured current government guidance was followed in relation to COVID-19. This included the use, storage and disposal of Personal Protective Equipment (PPE). For example, some bins were placed in communal corridors, with no lids and full of used PPE. These were removed by the second day of our site visit.
● Best practice was not always followed in relation to IPC Practices. For example, we identified during inspection some staff were wearing watches and their uniforms were not bare below the elbow. This demonstrated that staff were not following the provider's own IPC policy. The provider told us they would address this immediately after the inspection.
● Some areas of the service were not clean, and furniture was not always in good condition. For example, we found stains on chairs, carpets and tables chipped down to the bare wood. On the second day of the inspection the cleanliness of the home had improved.

IPC was not being effectively managed this placed people at increased risk of harm. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
● Some staff told us they had concerns about staffing levels. For example, shifts were not always covered when people were off work. Staff told us the mornings were a busy period and at times they felt rushed.
● The provider used a dependency tool to review and assess staffing levels. However, records did not always evidence care hours were assigned in line with the assessed levels. This made it difficult to see whether the current staffing levels were appropriate to meet people's current needs.
● Staff recruitment processes were in place and followed to ensure staff were suitable to work in a care home environment.

We recommend the provider reviews and audits their own dependency assessments and care hour allocations

Systems and processes to safeguard people from the risk of abuse
● Some incidents of a safeguarding nature had not been identified and recorded appropriately.
● People's relatives were happy with the care they received and felt they were safe. One relative told us, "Yes I am very happy with the care [Name] receives, they look after her well and I feel she is safe."
● Staff had received safeguarding training and knew when to report any suspected abuse to the management team.

Requires Improvement

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.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant the service management and leadership was inconsistent.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Continuous learning and improving care

- The provider had failed to take the appropriate action to improve the rating from the last inspection. We identified concerns we had found at the last inspection including; gaps in the recording on monitoring charts; a lack of guidance for staff to manage known risks to people.
- At the last inspection systems had not been effective to ensure CQC were notified appropriately. Although systems had been implemented, they had not always identified when notifications had not been submitted.
- Lessons had not always been learnt and improvements embedded. For example, the Local Authority IPC Team had visited and made recommendations prior to our inspection. We identified some of these concerns on our site visit meaning any actions taken had not been sustained.
- The current governance and oversight were not robust enough to ensure risks to people's health, safety and welfare were consistently managed to provide good outcomes for people.
- Records management was inconsistent. The provider lacked oversight to ensure appropriate monitoring and/or other records were in place, accurately completed and/or up to date.

The failing to ensure systems were in place to monitor and improve the quality and safety of the service, and the failure to maintain adequate records were breaches of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

- Following the inspection, a previous area manager had commenced employment and was supporting the service to make the required improvements.
- People and their relatives were happy with the support they received. One relative told us, "[Name of person] has always been well looked after and staff treat families well, they are willing to speak to you and are very friendly and caring."

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 not always submitted notifications about events such as serious injury and safeguarding incidents to CQC as they are required to do by law.

The failure to notify as required was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. We are dealing with this matter outside of the inspection process.

● The culture of the service was not always open and honest. During the inspection process one person's medication administration records were falsified. This was raised with the provider and they took action to address this.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

● We received mixed feedback regarding the support from the management team. Some staff felt well supported but others didn't always feel they were listened to.
● The provider had taken steps to support staff wellbeing including making them a break room, with music and drinks to take time to relax.
● People's relatives felt involved and well informed of their relative's care and support. One relative told us, "They [staff] keep me well informed by telephone or by email."
● Satisfaction surveys and informal chats were carried out to gather people and their relative's views.

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 had failed to effectively assess, review and manage risks to people's safety. The provider had not ensured the proper and safe management of medicines. Regulation 12 (2) (a) (g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to assess, monitor and improve the quality and safety of the service. The provider failed to mitigate the risk to people's safety. The provider failed to keep accurate and contemporaneous records. Regulation 17 (2) (a) (b) (c)