Speciality Care (UK Lease Homes) Limited

Riverside Court

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We inspected Riverside Court on 29 and 30 March 2017. The first day of the inspection was unannounced. This meant the home did not know we were coming.

Riverside Court is a care home registered to provide nursing and residential care for up to 61 people. It consists of one building with two floors. All bedrooms are single with ensuite facilities. The home is divided into four separate units, each of which can accommodate 15 people. The home manager told us their office used to be a bedroom, and so the home actually contains 60 single bedrooms, not 61.

Clyde Unit provides residential care for people living with dementia. Shannon Unit provides nursing care for people living with dementia. Trent and Avon Units both provide nursing care; some people on these units were also living with dementia.

On both floors there are communal lounges and dining rooms. Both floors also have shared bathrooms, toilets and shower rooms. The home has an enclosed garden area with seating.

At the time of this inspection there were 55 people living at the home.

Riverside Court was last inspected in October 2015. At that time it was rated as 'Requires Improvement' overall. It was deemed to be 'Requires Improvement' in the domains of Safe, Responsive and Well-led, and 'Good' in the domains of Effective and Caring. We found breaches of regulation in relation to staffing, medicines management, audit and monitoring, and record-keeping.

The home had a registered manager, although they had recently become the manager of a different home run by the same registered provider. A registered manager from another home run by the same provider had commenced employment at Riverside Court two weeks prior to this inspection. The plan was for them to apply to be the registered manager at Riverside Court. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Risks to people were not always assessed fully with care plans put in place to manage them. Risk assessments and care plans were not always updated after incidents had occurred. There were no plans in place to inform staff how to support people to bathe or shower safely.

Medicines administration was person-centred and we saw some examples of good practice in this area. However, we identified concerns with medicines management and recording; this was a breach of regulation identified at the last inspection in October 2015. The home manager was aware of the problems and had already organised an external medicines audit to help create an action plan for improvement.

People's care files did not always contain a complete and contemporaneous record of their care and support needs. This was a breach of regulation identified at the last inspection in October 2015.

We identified concerns with staff adherence to good practice in infection prevention and control at the home.

Existing staff told us they felt supported by managers at the home and had access to training and supervision. The induction of new staff was not documented, Care Certificate records had not been completed and competency checks on staff new to care had not been done.

Compliance with the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS) across the home was mixed. We saw some examples of good practice in terms of mental capacity assessments and best interest decisions, whereas others were lacking. Applications for DoLS for three people who lacked capacity to consent to living at the home had not been made.

People and relatives told us care staff respected their privacy and dignity and most interactions we saw evidenced this. However, we did observe some occasions whereby people's privacy and dignity was not maintained.

Feedback from people and their relatives about the food served at the home was positive. We observed people received support to eat and drink when they needed it. Records kept of people's food intake lacked the detail required to make them meaningful.

Audit and monitoring at the home had failed to address breaches of regulation identified at the last inspection in October 2015 and the additional breaches identified at this inspection.

People's care files could not clearly evidence how they had been involved in designing and reviewing their care and treatment. Not all care files contained people's personal histories and those we did see had not been used to individualise people's care plans.

Records showed all the appropriate checks had been made to establish staff recruited to the home were suitable to work with vulnerable people. People told us they felt safe at Riverside Court and staff could describe how they safeguarded people from harm.

A full range of checks had been made on the building, its utilities, facilities and equipment in 2017. There was a gap in records of three months at the end of 2016 when there was no maintenance worker in post. No issues had arisen as a result of this.

The home had been adapted to better meet the needs of people living with dementia using current good practice in dementia care environments.

People told us they had access to a range of healthcare professionals to help meet their wider health needs. The home was part of the local Vanguard project, which meant people had greater access to a range of healthcare professionals.

People and their relatives told us the staff at Riverside Court were kind and caring. We observed lots of friendly and supportive interactions between care staff and people; there was a homely atmosphere and plenty of laughter was shared.

People had access to advocacy services if they needed them. An independent advocate visited people at the home on a regular basis.

Staff could describe what was important in terms of end of life care. The home manager planned to review and update people's end of life care plans with them and their relatives to make sure they contained their personal preferences.

People told us they had enough to keep them busy. We saw the home provided a range of meaningful activities for people to take part in.

A formal complaint received since the last inspection had been investigated and responded to appropriately. People and their relatives felt happy to complain if they needed to, which suggested the culture at the home was open.

People and their relatives told us the home was well-led. Staff gave us positive feedback about the new home manager. Since joining the service, the home manager had used audit, monitoring and feedback to generate an action plan for the service.

People, their relatives and staff had regular meetings with management at the home. They told us they were asked for ideas and feedback. A 'You said, we did' board explained how feedback had been used to make positive changes at the home.

The registered provider had merged with another healthcare provider and were adopting their vision and values, what they called their 'purpose and behaviours'. These included 'putting people first', 'being a family, and, 'acting with integrity.'

We found breaches of the Health and Social Care Act (HSCA) 2008 (Regulated Activities) Regulations 2014, in relation to safe care and treatment, staffing, safeguarding service users, consent, dignity and respect, and good governance. You can see what action we have told the provider to take at the back of the full version of the report.

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.

We identified concerns around medicines management and administration.

Risks to people were not always assessed and managed appropriately.

We observed some care staff did not abide by infection prevention and control good practice.

People told us they felt safe and there were enough staff deployed at the home.

Is the service effective?

Requires Improvement

The service was not always effective.

Experienced staff had access to the supervision and training they needed to support people effectively. Records of staff induction and the Care Certificate were lacking.

Compliance with the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards varied across the home.

People and their relatives gave us positive feedback about the food and drinks served at the home.

Records showed, and people told us, they had access to a range of healthcare professionals to help support their wider health needs.

Is the service caring?

Requires Improvement

The service not always caring.

People and relatives said staff were caring. Most interactions we observed were supportive, although we saw staff did not always respect people's privacy and dignity.

It was not clear how people had been involved with designing

and reviewing their care plans.

Care staff knew people well as individuals. People had access to advocates if they needed them.

Staff could describe the important aspects of end of life care although people's end of life care plans lacked detail.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Some care plans were detailed and person-centred, whereas others were not. This was an issue at the last inspection in October 2015.

We saw people had access to a range of meaningful activities. People told us they enjoyed the activities on offer.

People and relatives told us they felt confident to complain if they needed to.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Audit and monitoring since the last inspection had failed to rectify breaches of regulation or prevent further breaches.

Since commencing work at the home two weeks prior to this inspection, the new home manager had used audit and feedback to create an action plan for improvements required.

People, their relatives and staff at the home were asked to feedback about the service at regular meetings and via surveys.

Notifications had been correctly submitted and the ratings from CQC's last inspection were displayed.

Riverside Court

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 29 and 30 March 2017. The first day was unannounced. The inspection team consisted of two adult social care inspectors and one 'expert by experience' on the first day of inspection, and two 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. The expert by experience on this inspection had been a user of healthcare services for many years and had supported adult social care inspectors on numerous other inspections.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We used this information to help plan the inspection.

As part of the inspection we reviewed the information we held about the service and requested feedback from other stakeholders. These included Healthwatch Wakefield, the local authority safeguarding team and the Clinical Commissioning Group. They did not share any concerning information with us. After the inspection we spoke with an advocate who visited people at the home on a regular basis and a member of the Vanguard project team; they both gave positive feedback. Vanguard is an NHS project to join up health and social care services through partnership working. Riverside Court is one of the Wakefield care homes taking part in the project.

During the inspection we spoke with six people who used the service, eight people's relatives, six members of care staff (including nurses), the activities coordinator, the home manager, the clinical lead, a domestic worker, the maintenance worker and a cook.

We spent time observing care in the communal lounges and dining rooms and used the Short Observational Framework for Inspections (SOFI), which is a way of observing care to help us understand the experience of

people using the service who could not express their views to us.

As part of the inspection we looked at seven people's care files in detail and selected care plans from eight other people's care files. We also inspected five staff members' recruitment and supervision documents, staff training records, 10 people's medicines administration records, accident and incident records, and various policies and procedures related to the running of the service.

Requires Improvement

Is the service safe?

Our findings

People we spoke with told us they felt safe at Riverside Court. One person said, "Yes, I feel safe here. They take good care of me." A second person told us, "I feel perfectly safe", and a third said, "Yes, I do feel safe. I never have anything to worry me." Relatives agreed. One told us, "[My relative] is safe here, definitely", and a second said, "[My relative] feels safe. There are no problems with the other residents."

We inspected care files to determine how risks to people had been assessed and managed. Care records we saw contained risk assessments for various risks such as mobility and falls, skin integrity, nutrition and infection control. These had been reviewed on a regular basis. We found gaps in how risk was managed for some people and identified times when care plans to manage risk had not been updated following incidents. For example, none of the people at the home had a care plan in place to tell staff how to support them safely to bathe or shower. One person's hygiene care plan stated they needed to be hoisted into a shower chair to shower, however, care staff told us the person could not sit unsupported and went into the shower in their special recliner chair. This meant staff following the person's care plan to provide assistance with showering would put the person at risk of falling.

Two people on one unit had fallen in February 2017 and sustained hip fractures. Each incident had been documented, however, when we checked their mobility and falls risk care plans, neither had been updated since the injuries, and evaluations of the care plans completed monthly also did not state each person had fractured a hip. Risk assessments and care plans in place did show both people were at high risk of falls and contained measures to minimise their risk of falling. However, the home had not adjusted mobility care plans after the fractures to inform staff each person's ability to mobilise would be compromised as a result of their hip fracture, thereby putting them at higher risk of further falls.

Another person's care records contained conflicting information about how they should be hoisted. The person's moving and handling care plan stated they needed a medium sized sling, whereas their moving and handling risk assessment stated they needed a large sized sling. Daily records kept in the person's room stated the person needed a small sized sling for hoisting, and care staff we spoke with confirmed this was what they used as the person had a small stature. This meant staff who did not know the person who followed the person's care plan to hoist would put the person at increased risk of falling by potentially using the wrong sized sling.

Risks to people's skin integrity had been assessed and we saw care plans were in place. Daily records showed people who needed it were assisted to reposition regularly in order to reduce their risk of pressure ulcers. One person had an air mattress in place to help reduce their risk of developing pressure ulcers; they did not have any pressure ulcers at the time of this inspection. When we checked to see if their mattress was on the correct pressure setting for them, we saw it was set much too high, thereby increasing their risk of pressure ulcers. Care staff were meant to record the pressure of the mattress each time the person was assisted to reposition. We saw they had consistently recorded a pressure setting which was too high for the person, and this did not agree with the actual pressure setting the mattress was on, on the day we inspected; that was even higher. This indicated staff were not checking the mattress pressure settings. We

raised these concerns with the home manager. They immediately asked a nurse to check all air mattresses in the home were on the correct setting for the person using them, and spoke with care staff about the checks they made and recorded.

In the same person's daily records which were kept in their bedroom we found instructions from a physiotherapist dated June 2016 describing exercises for care staff to do regularly with the person to help ease contractures of their body. When we asked two care workers about these exercises, one of whom who had just written in the person's daily records, they knew nothing about them and had never assisted the person to do them. We raised concerns with the home manager. They could not explain why this information was in the person's daily records and had not been turned into a care plan for staff to follow. They asked the physiotherapist to reassess the person to ensure the exercises were still appropriate; the person was seen shortly after the inspection and their care plans were updated.

Issues with risk assessment and management were a breach of Regulation 12 (1) and (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as people had been placed at risk of receiving unsafe care and treatment or had not received the care recommended by healthcare professionals.

We identified some good practice in terms of risk management, whereby people had been supported to take positive risks. One person had been assessed by a speech and language therapist as being at risk of choking and advised to drink fluids which had been thickened to make them safer to swallow. The person had decided they did not want to have their drinks thickened. Care staff at the home had assessed the person as having the mental capacity to make the decision and documented the advice they had provided. The person was provided with drinks without thickener. Another person had requested bedrails on their bed but did not want to use the 'bumpers' (padding) placed over bedrails to lower the risk of entrapment. Once again care staff had assessed the person's mental capacity to make the decision and recorded their understanding of the risk of not having bumpers deployed. These were good examples of people being supported to take positive risks.

At the last inspection in October 2015 we identified a breach of regulation relating to safe care and treatment, as one care worker did not ensure the medicines trolley was locked and secure when leaving it to administer medicines to people. At this inspection we observed one medicines round on the dementia nursing unit and identified similar concerns. The staff member administering medicines placed the trolley with its doors open in the doorway of the person's room to whom they were administering medicines; other medicines in blister packs were left on top of the trolley. People were seen to be mobilising independently around the unit during the medicines round and were therefore not safeguarded against access to medicines.

The care worker started the medicines round by checking the temperature of the room and fridges where medicines were stored. Records showed this was done on a regular basis and temperatures were within the desired range. They also washed their hands, then proceeded to administer medicines to people depending on whether they were awake and sufficiently alert. One person asked to have their medicines after eating their breakfast; the care worker respected the person's request and went back after they had eaten their breakfast. Another person was still asleep at 9am so the care worker did not disturb them, telling us, "If it's a once a day medicine, as long as I can give it in the morning it's OK."

Medicines administration was very much person-centred and not rushed. The care worker spoke calmly and respectfully to people as they supported them to take their medicines and clearly knew people well as individuals. One person was asked if they had any pain; they said they had and requested a pain-killer. The

care worker told them, "I'm going to rub some cream on it and then in half an hour you can tell me if it's gone." People we spoke with about their medicines were happy with the support they received. This meant people received their medicines in a caring and respectful way.

Most people's medicines were supplied by the pharmacy in blister packs, but some were in boxes or bottles. We saw the care worker checked people's medicine administration records (MARs) before administrating the medicines and then signed them afterwards. If people refused their medicines, this was also noted. People prescribed medicines 'when required', in other words, to be taken as and when they needed them, had protocols in place to describe when and how often they could be given by staff. We saw care staff had sought advice from the pharmacy about one person, who was often asleep when their 7am medicine was due. Pharmacy had advised the medicine could be given safely later, meaning the person would not be unnecessarily disturbed. Two people given essential medicines covertly that they would otherwise refuse due to their dementia diagnoses, had all the correct mental capacity assessments and documentation in place. These were good examples of person-centred medicines management.

When we checked 10 people's MARs from two different units at Riverside Court to determine whether medicines administration was recorded correctly we found there were issues. There were gaps in two people's MARs, where care staff had not signed to show medicines had been administered. Some people's printed MARs from pharmacy contained handwritten additions. When medicines are added by staff it is good practice for these to be checked and countersigned by another member of staff to make sure the instructions are correct. We saw three MARs contained handwritten medicines that had not been countersigned. This was an issue highlighted at the last inspection in October 2015. Medicines were dispensed by pharmacy in a four-weekly cycle and each of the four units had their own file containing people's MARs. We found several MARs in each file were falling out because the holes in the paper were ripped. If these were to be lost there would be a risk people would not be administered the medicines they needed.

Medicines were safely and securely stored in a central clinic room at the home, in between administrations. We checked the storage and recording of controlled drugs such as strong pain-killers and counted some medicines to determine whether they tallied with stock recorded in the controlled drugs register. The records we sampled were correct. When we tried to reconcile other non-controlled drugs we experienced problems. For example, one person was prescribed Lorazepam 'when required' for anxiety. Their MAR showed it had been administered several times on the preceding two weeks, and this had been inconsistently recorded by staff on three different stock control sheets in the MAR folder so we could not establish how many tablets should be left. Stock levels for other boxed medicines were recorded intermittently on people's MARs, making it difficult to identify accurate stock levels. Another person's MAR showed they had not been given Adcal vitamin supplements for three days in March 2017; the MAR indicated they were not in stock. When we checked with care staff we were told the care worker attempting to administer the medicine had not realised it came in weekly tubes and more stock was actually in the trolley. This meant that people were not receiving their medicines as prescribed by their GP.

The clinic room contained six overflowing bins of medicines waiting to be returned to pharmacy; we were told a collection had been arranged for the week of our inspection. Records kept of the unused medicines returned to pharmacy were not consistently countersigned by a second member of staff. This is an important safeguard to ensure medicines are disposed of correctly.

We informed the home manager about our concerns around medicines management at the home. They said they were aware of most of the concerns we listed as they had been raised by care staff and identified in recent audits. They felt a lot of issues stemmed from the use of agency care workers. The home manager

had requested a detailed medicines audit by an external company which had taken place the week before this inspection, and were awaiting the results. From this audit they intended to implement an action plan. Since starting as the home's new manager two weeks prior to this inspection, they had already met with the deputy manager and clinical lead to discuss issues with medicines management and put in place new internal audit arrangements with the aim of driving improvement. The clinical lead and deputy manager were also liaising with the pharmacy the home used to discuss issues they had experienced and to identify ways to improve; a meeting had already been arranged. This meant the concerns we found were already known to the management team, however, the changes needed to rectify the problems had yet to be implemented.

Issues with medicines management were a continuous breach of Regulation 12 (1) and (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

On the days of our inspection the home appeared clean and tidy and there were no unpleasant odours which lingered. People and their relatives told us the home was clean. Comments included, "They clean it (the home) all the time. Every day", and, "It's tidy and clean. Nothing to grumble about."

During the medicines round we observed the care worker checking two people's pain patches were in place by touching their upper shoulder areas with bare hands. They did not wash their hands after this or at any other point during the medicines round. Two people required the application of topical medicines: a pain-relieving gel to one person's shoulder and knee, and some eye drops. The care worker used gloves for this, but then placed the used gloves on top of the medicines trolley afterwards and did not wash their hands. Poor hand hygiene placed the people receiving medicines at greater risk of infections.

We also observed a care worker enter a person's room to support them with personal care. Daily records showed the care worker had checked the person's incontinence pad but we saw there was no personal protective equipment (PPE) in the person's room, so the staff member could not have used it. PPE was stored on a trolley which the care staff on each unit shared.

One care worker was seen to leave bags containing clinical waste and soiled linen unattended on the floor of a corridor when they went into a person's room to support them. Another person's bathroom had packs of incontinence pads stored on the floor, with an open pack on the closed toilet lid. We noted a different care worker had long false nails, which may pose an infection control risk to people, although all other staff were seen to be 'bare below the elbows' which is good infection control practice. The home manager acknowledged they had work to do in terms of improving infection control procedures at the home and we noted care staff had already received supervision specifically around infection prevention and control.

Issues with infection prevention and control had been identified during audits at the home in 2016 and 2017. One of the nurses had recently been appointed as infection control lead for the home. They were in the process of working through an action plan and undertaking observations of the care staff as they carried out certain tasks, such as catheter care and people's personal care.

Concerns around infection prevention and control were a breach of Regulation 12 (1) and (2) (h) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

At the last inspection in October 2015 we identified a breach of regulation relating to staffing as there were not sufficient members of suitably qualified staff deployed to meet people's needs. At this inspection we analysed the home's dependency tool used to calculate staffing levels and checked rotas to examine whether shifts in the preceding four weeks had been fully staffed. We also spoke with people, their relatives

and members of the care team on duty.

People told us that whilst staff were busy, they did not wait long for their needs to be met. Their relatives agreed. Comments included, "There are enough staff", "Not enough in my opinion, they rush around", "If I buzz they bob in very quickly", "You only wait for two to five minutes, nearer two (minutes)", "There are enough (staff) for what [my relative] needs", "There are enough. They pay [my relative] a lot of attention and spend time with [them]", and, "Usually there are (enough staff), sometimes they struggle."

Care staff also told us there were enough staff at the home, and that staffing levels had increased in 2017. One care worker told us, "Staffing is getting better, definitely. We've got a nurse per unit now, it's so much better", a second care worker said, "We have got more staff lately", and a third commented, "Over the last 2 months it's a lot better. It was hard when there were only two nurses."

The home manager explained how the dependency tool and the home's audit of accidents and incidents had been used to evidence the need for increased staffing. An extra nurse had been deployed on day and night shifts, so there was one per nursing unit during the day and two in total at night. An extra care worker had also been added to the day shift plus an additional activities coordinator, on a part time basis. Rotas showed agency care workers were still being used regularly, although the same workers were booked in advance to ensure consistency. The home manager told us new nursing staff were being recruited, including one newly qualified nurse who was being supported on a supernumerary basis during their preceptorship period.

We arrived early both days of this inspection and made observations of staffing levels and response times to call buzzers until early evening. We saw people received the support they needed and buzzers were answered in a timely way. Feedback from people, their relatives and staff, plus our observations showed there were now sufficient staff deployed to meet people's needs and keep them safe. This meant the previous breach in regulation had been resolved.

We inspected the recruitment records of five staff members employed at the home since the last inspection. Most of the documentation was available. This included an original application form, references from previous employers, copies of photographic identification, proof of address and a Disclosure and Barring Service (DBS) check. The DBS helps services make safer recruitment decisions. We noted two staff members had gaps in their employment history. After the inspection the home manager provided evidence in the form of CVs for each staff member which showed a full employment history; they had been stored in the registered provider's electronic system and not printed out for inclusion in their personnel files. This meant the recruitment process at the home was robust and helped reduce the risk of unsuitable candidates being employed to work with vulnerable people.

Requires Improvement

Is the service effective?

Our findings

People and their relatives told us staff at the home had the skills and experience they needed to provide effective support. Comments included, "Yes, they are trained and do things right", "They know what they are doing", and, "Yes, if they need to they will get in others with the right skills."

Care staff told us they had received supervision sessions at Riverside Court and felt supported by the home manager and deputy manager. A supervision matrix was in place which evidenced most staff were up to date with their supervisions with more senior staff, although the home manager said they had not received supervision in 2016 or 2017 and was seeking to address this. Supervision records showed sessions were a combination of open discussions with staff or themed discussions based upon issues which had occurred at the home, for example, problems with infection control practice.

Annual appraisals of staff had last been completed in January 2016. The home manager said they had arranged annual appraisals for all staff for the month following this inspection. As they were new to the home, the home manager planned to do these with the deputy manager because they did not know all the staff well yet. The home manager told us, "I need to look at the staff training needs and skills and put a training plan in place."

Staff we spoke with said they had access to training and could request further training if required. Nurses told us they were in the process of developing their clinical practice with courses on catheterisation and taking blood samples. The clinical lead had also requested training from tissue viability nurses on wound care for nursing staff at the home. The home manager was setting up a revalidation group for the nurses at the home so they could provide and receive peer support to maintain their professional registrations.

The training matrix showed the majority of staff were up to date with various training courses, such as fire safety, safeguarding, moving and handling, basic life support, and health and safety. Staff whose training had expired had been booked onto training courses. This meant existing staff received the support they needed to provide effective care for people.

Care workers told us they had received an induction when they started work at the home. This had involved shadowing existing employees and attending training. One care worker said of their induction, "It was really good." We noted staff personnel files contained no information about their induction, and the files of employees new to health and social care did not include information about the Care Certificate. The Care Certificate is an introduction to the caring profession and sets out a standard set of skills, knowledge and behaviours that care workers follow in order to provide high quality, compassionate care. Completion of the Care Certificate involves learning theory and the testing of competence. Homes are expected to either implement the Care Certificate or provide an in-house induction which includes all aspects of the Care Certificate. The home manager acknowledged employees new to health and social care had not been enrolled on the Care Certificate documentation and competency checks had not been completed. This was already on their action plan for the home.

The home could not evidence how newly employed staff had been inducted to the home. This was a breach of Regulation 18 (1) and (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

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

Records showed the home had applied for DoLS authorisations for some people who lacked capacity to consent to living there and DoLS care plans had been put in place. However, we identified three people at the home who were living with dementia and lacked capacity to consent to living at Riverside Court who did not have DoLS authorisations in place. One of these people had been at the home since 2012. The home manager had already audited the DoLS records since coming to the home and created an action plan of people who needed authorisations for DoLS and we saw these three people were on the list.

Deprivation of people's liberty by the registered provider without legal authorisation was a breach of Regulation 13 (5) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Care assistants could describe how they helped people to make decisions by giving them choices and nurses could explain the process of assessing mental capacity and making best interest decisions. Quality of MCA records for specific decisions was mixed. The care files of some people, particularly those on the dementia units, contained a full range of MCA assessments and best interest decisions, such as consent to care and treatment, consent for photographs, the use of recliner chairs, receiving medicines covertly, and the use of bedrails.

On other units some MCA assessments and best interest decisions were lacking. For example, one person with advanced dementia only had MCA assessments and best interest decisions for the use of a recliner chair, having their photograph taken and emergency evacuation. Despite being completely reliant on care staff for all care and treatment, including personal care, eating and drinking and medicines administration, their capacity to consent to this support had not been considered. A second person's care records were difficult to interpret as they had signed a consent form for having their photograph taken but there was an MCA assessment and best interest decision in place for safe evacuation in an emergency. This person's medical history showed they had a learning disability and dementia; however, they had no care plan for their cognition so it was unclear how either diagnosis affected their ability to make decisions.

Not all people had been fully assessed for their capacity to consent to their care and treatment. This was a breach of Regulation 11 (1) and (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

We discussed these issues with the home manager. They told us they were already aware of the issue, and the review and improvement of MCA assessments and best interest decisions was part of their action plan for the home. We saw audits which evidenced this.

People who experienced behaviours which may challenge others had care plans in place to inform staff of the best ways to provide distraction and reassurance. Any incidences of challenging behaviour had been recorded on 'ABC' forms, which documented the triggers for the behaviour and how it was managed. Care workers on the units supporting people living with dementia had received training on supporting people with behaviours that may challenge and could describe the techniques they used. This meant people who experienced challenging behaviours were well supported by staff.

People and their relatives said appointments with healthcare professionals were arranged when they were needed. Comments included, "Yes, they get the doctors for you", "They got a dietician in because [my relative] doesn't want to eat", and, "They get a doctor in if needed."

People's care records evidenced they had seen a range of healthcare professionals, including GPs, social workers, dieticians, and speech and language therapists. During the inspection we observed healthcare professionals from various services coming in to see people. The home was part of a trial to integrate health and social care called the Vanguard project. This gave people at the home greater access to a multidisciplinary team of healthcare professionals. The clinical lead told us, "They look at the person more holistically – as a whole", and continued, "The physio (physiotherapist) that comes here has had a lot of input." The home manager agreed, and said they had a meeting arranged with the physiotherapist the week after this inspection to discuss the equipment used to support people. Feedback we received from the Vanguard team about the home was positive. This meant people were supported to maintain their wider health.

Feedback about the food and drinks served at Riverside Court from people and relatives was positive. Comments included, "The meals are very nice", "The food is alright", "There are drinks and snacks all the time", and, "The food's nice. There is plenty of it."

We observed two meals during the inspection and one of our inspection team ate a meal with people using the service. Tables were set appropriately with tablecloths, napkins, cutlery and condiments. People who preferred to dine in their rooms received their meals there. We saw people were given a choice of foods and were asked by care staff if they had eaten enough or wanted more. People who needed support to eat received this in a respectful and unhurried manner. A trolley went round regularly between meals to offer hot and cold drinks as well as homemade cakes and other snacks.

We looked around the kitchen and spoke with one of the cooks. They could explain how they modified foods for people with special requirements, such as texture or low sugar for diabetes. The most recent food hygiene inspection at the home in December 2015 had given a rating of five out of a possible five, which meant the standards of hygiene were 'Very good'.

We found details of people's specific nutrition needs in the kitchen. These were all correct apart from the fortified diet requirements of people on one unit were missing. The cook could describe the meals each person needed, and accurate records were kept in the dining room of the unit where care workers served meals, so this appeared to be an administrative issue. We checked records of people who needed a fortified diet on that unit and saw they were receiving them. The home manager ensured records were updated immediately.

The home kept records of the food and fluids consumed by people at risk of weight loss, however they lacked the detail required to make them meaningful because the amount of food the person was served was not recorded. Without recording how much food was served to the person it cannot be established how much they ate. We fed this back to the home manager. They discussed this with senior staff at their daily

meeting on the second day of this inspection and a decision was made to agree standard portion sizes so records kept would be more accurate.

Riverside Court had been adapted to help meet the needs of people living with dementia. Corridors were pale in colour and handrails had been painted in contrasting colours to stand out. People's doors had been painted different colours and those doors reserved for staff were painted the same colour as the walls to make them less obvious. Picture signage was available to help direct people to communal areas, bathrooms and toilets. Pictures and murals adorned the walls to help promote a homely feel, and people's rooms had pictures outside which they had chosen or had special meaning for them. The home manager told us a new colour scheme had just been agreed for the communal areas of the home which had been based upon guidance from the University of Stirling, a renowned centre of excellence in dementia research. Those people whose bedrooms were due for redecorating had a range of colours they could choose from, although the maintenance worker told us if they did not like the colours offered, they could have anything else they liked. This meant the home had been modified to better meet the needs of those people living with dementia.

Requires Improvement

Is the service caring?

Our findings

People and their relatives described staff at the home as kind and caring. Comments included, "They are lovely carers", "Good, kind and caring", "Kind, caring – nothing is too much trouble", "They are absolutely lovely, they do try, they are brilliant", and, "The staff are brilliant, kind and caring and much more."

Comments from a relatives' survey conducted in 2017 included, "The staff are very caring", "The most important thing is we can leave our loved ones knowing they are well cared for and happy", and, "It is homely and feels like a big family. Friendly and fun staff."

During both days of this inspection we observed numerous examples of positive and caring interactions between all staff at the home and the people they supported. Care staff could describe people's likes, dislikes and preferences and it was clear they knew people well as individuals. We saw smiles, and heard laughter and banter exchanged between people and care staff. One person living with dementia liked to express affection towards the staff on their unit. We saw staff returned their hugs and allowed the person to kiss their cheeks, which made the person feel happy and reassured. This meant care staff knew how to provide care that was person-centred.

We observed there was a warm and homely atmosphere at Riverside Court. When we asked people and their relatives what they thought of the atmosphere at the home they told us, "It's good. Friendly and homely", "It's a friendly place to live", "The home is fun. Nice, with a family feel. There is an upbeat attitude", and, "It's cheerful and homely."

People we spoke with told us care staff respected their privacy and dignity. One person said, "They close the door for privacy if they are doing things for me", and a second said, "They treat me with respect and look after my dignity." We saw people were dressed appropriately for the time of year and appeared well groomed. Care staff told us they respected people's privacy and dignity when supporting them with personal care. One care worker said, "We close the doors and keep people covered up during personal care." We also saw care staff communicated well with people and asked for their consent before providing support.

We arrived at 7am on the first day of this inspection and noted some people's doors were open when they were in bed and other people had their doors closed. One member of staff could not explain the reason why some doors were open and others closed, and another staff member said the closed doors were of those people who were still asleep. We observed some of the people with open doors were still asleep. When we checked people's care plans we saw in some cases people's preferences for having their door open or closed was recorded, but in some it was not. We discussed this with the home manager and they said they would review people's preferences and make sure they were recorded.

On the first day of inspection we heard a person shout for support from their room. We noted the door to their bedroom was open and their bathroom door was ajar; they were asking for a care worker to help them off the toilet. Although they could not be seen using the toilet from the corridor, the circumstances still

meant the person's privacy and dignity had been compromised by the care worker who assisted the person onto the toilet. On another occasion we observed a care worker applying a topical pain-killer to a person's shoulder and knee whilst the person was in bed wearing their night clothes. The care worker left the bedroom door wide open and pulled back the person's bedcovers in order to apply the cream. This care worker also did not maintain the privacy and dignity of the person they were supporting.

People's privacy and dignity was not always maintained or respected by care staff. This was a breach of Regulation 10 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Each unit had an office where people's care records and other management information was stored. During the inspection we noted offices on Trent, Shannon and Avon were frequently left unlocked and unattended at various times throughout the two days we were there. This meant people's private information was not always stored securely.

People's care files did not clearly evidence how they had been involved in making decisions around their care and treatment. In some care files we saw review forms used when meetings were held with people and their relatives but they did not detail the discussions held or what opinions or input people had. For example, one review form listed a person's care plans and had been signed by them but the only note written was '[Name] would like some new slippers.' This meant people may not always be involved in the reviewing and revising their care plans.

Some care plans we saw lacked information about people's personal histories and those that did contain personal histories did not evidence how this information had been used to individualise their care plans. Personal histories are very important, particularly when supporting people living with dementia. This is because people with dementia can often feel they are living in a time in their past, and speak about events, circumstances and people who were important to them at that time. Having this information can allow care staff to plan individualised care to better support the person. We raised our concerns about people's involvement in their care plans and the lack of personal histories. The manager said they were already aware of this issue and meetings with people and their relatives were planned so care plans could be reviewed and improved.

The home manager could describe how and when to refer people to advocacy services. Information was available to people about how to access advocacy services and records showed people had been supported by advocates when they needed them. After this inspection we spoke with an advocate who was a regular visitor to the home, spending time with those who either did not have families or who had families living far away. They told us, "The staff I've seen are really caring", and that they were always made to feel welcome. This meant people had access to independent support to make decisions when they needed it.

We asked the home manager how they promoted equality and supported people's diverse religious and cultural needs. They explained the pre-admissions assessment process used to assess potential new admissions included asking about people's religious and cultural needs. We found the home manager was knowledgeable about the religious and cultural requirements relating to aspects such as food, the gender of care staff and death practices for various religions. No one at the home had non-Christian religious needs at the time of this inspection. The home manager told us if there was to be an admission of a person with different religious or cultural needs, "I'd have a session with staff to explain the religion and what we needed to do." In terms of supporting people's preferences around sexuality, the home manager said, "We speak to individuals to find out how they want to be supported. We'd ask people who they want to know about their preferences." This meant the home promoted people's equality and respected people's cultural and religious diversity.

We noted people's DNACPR forms, if they had them, were located at the front of their care files. The DNACPR or 'do not attempt cardiopulmonary resuscitation' decisions had people's correct name and address details on. This meant information was up to date and easily available for care staff when needed.

Riverside Court provided end of life care to people if it was their preferred place of death and their needs could be met. We saw posters advertising training on palliative and end of life care courses for staff run by the charity MacMillan and one nurse told me they had enrolled. The clinical lead explained how a new member of care staff had worked in a hospice for many years, so there were plans in place for them to share learning and support other nurses with clinical skills such as the use of syringe drivers for pain and symptom management.

We asked care staff what they thought was important in terms of care and support for people near the end of their lives. Replies included, "We need to respect their wishes. It needs to be dignified. We manage any symptoms. It's private and we look after the family as well", and, "It's making sure they're comfortable and meeting their needs. We need to understand their family background and manage their symptoms." This meant staff could demonstrate an awareness of the important aspects of good end of life care.

People's care files contained death and dying care plans, however, we saw they contained very little information about end of life care and focused on funeral arrangements. The home manager said they were aware of the lack of person-centred detail these plans contained and intended to address this at the meeting planned with people and their relatives to review and update all of their care plans.

A remembrance tree was located in the foyer to the home. Relatives and friends were asked to hang tags on the tree with the name of their loved one. This meant the home had provided a means for relatives and friends to remember people who had lived at Riverside Court after they had died.

Requires Improvement

Is the service responsive?

Our findings

People and their relatives told us they felt confident to feedback to staff at Riverside Court if they needed to. One relative said, "I have no complaints. I would make one if I wanted to."

At the last inspection in October 2015 we found a breach of regulation relating to good governance as people's care files did not always contain a complete and contemporaneous record of their care and support needs. At this inspection we checked to see if improvements had been made.

The quality of people's care plans at the home was mixed. Some people's care plans for aspects such as mobility, communication, nutrition, continence and personal hygiene were detailed and person-centred. Some care files contained care plans for specific conditions such as diabetes, coeliac disease, behaviours that may challenge others and epilepsy, which were also individualised and detailed. All care plans we sampled, regardless of quality, had been evaluated on a monthly basis.

Other people's care plans lacked detail or were generic. For example, one person on Trent Unit since 2012 had advanced dementia; we noted there was no care plan in place to inform staff how their condition affected them or what personalised support they required. The person also used a recliner chair. We noted a care plan was in place for this; however, it was a generic printed document which we saw in other people's files who also used recliner chairs. Recliner chairs can be used for a variety of reasons, and the person's file did not make it clear why they needed one. The person's oral assessment stated a care plan for oral care must be completed if a person needed support with their oral care; the person needed full support with oral care and no care plan was in place. We saw daily records showed the person was receiving support with their oral care. However, this meant care workers did not have all the information they needed to ensure people received person-centred care.

Another person's care file stated they were a diet controlled diabetic. We noted their nutrition care plan made no mention of this; it described the person as needing a fortified and pureed diet only. They had no separate diabetes care plan in place. We checked with kitchen staff and care workers; they were all aware the person was a diabetic and needed a special diet. However, the lack of accurate and contemporaneous information in the person's care plan meant their needs may not be met by staff who did not know the person well, for example, agency care staff.

People had a standard set of care plans in place, which meant some people had care plans which were not relevant to them. For example, people with no history of chest disease or asthma had breathing care plans, which simply stated they had no problems with breathing. These care plans were evaluated monthly, along with people's other plans, so this was a waste of the care staff's time and did not represent person-centred care. The home manager agreed with this assessment. They said the review and improvement of people's care plans which was planned would include making sure people only had care plans for their identified needs.

People were at risk of inappropriate care because accurate and appropriate records were not always

maintained. This was a concern at the last inspection in October 2015 and evidenced a continuous breach of Regulation 17 (1) and (2) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Daily records evidenced the care people received from staff. Care staff we spoke with could describe people's needs and preferences, and people told us they were happy with the care they received at Riverside Court.

Care staff were updated about people's progress, any changes to their needs and upcoming events or healthcare appointments at handover meetings between shifts. We attended two handover meetings and were impressed with the level of detail discussed and shared between staff members. A communication book and appointments diary was also used by staff to make sure people received the support they needed when they needed it. Shortly before this inspection the home manager had revised the handover form used to include more detail about people's needs to better inform agency workers.

As discussed above, people living with dementia did not all have dementia care plans, so we asked staff what they thought responsive dementia care involved. One care worker said, "They need stability and reassurance. Everyone's different. You need patience and understanding, and to know the resident well", a second care worker told us, "It's about understanding them and the stage (of dementia) and symptoms they have. It's about being able to communicate and have time", and a third said, "It's mainly person-centred care. You do things how they like them." Our observations on the two units specialising in dementia care and on the other two units, evidenced care staff had the skills to provide good care and support to people living with dementia.

People and their relatives gave us positive feedback about the activities on offer at Riverside Court. Comments included, "There is always something going off in the lounges", "I am happy with the amount of stuff going on. The girls (care staff) take me to them", "[My relative] takes part in singing and keep fit. [My relative] does what they can", "People come into [my relative's] room and put on a CD and sing and dance for [them]", and, "They always ask if [my relative] wants to join in, but [they] can't do much."

Since the last inspection a second activities coordinator had been employed on a part time basis, to add to the existing full time activities coordinator. They told us about a range of activities that were on offer, including the regular library service, games, movies, reminiscence, walks, church services and one-to-one chats with people. Care staff had attended 'creative minds' training, which provided insight and techniques for supporting people living with dementia, including meaningful activities.

During the inspection we were introduced to two chickens which had been hatched in a cage in a lounge area on Trent Unit. This was part of an animal husbandry project which we were told had been very popular with the people at the home – one person actually stayed up late at night to watch the eggs hatch. The activities coordinator and one of the people cleaned the chickens out daily; the plan was for them to move into an outside run when they were old enough and supply eggs for the home.

Other activities we observed during the inspection included a movie afternoon in one of the lounge areas and a very enthusiastic parachute session where people sitting around the room waved a large piece of material up and down and sang songs. Our observations and feedback from people and their relatives showed people had access to sufficient activities and enjoyed those they took part in.

One formal complaint had been received by the home since our last inspection in October 2015. Records showed a full investigation had been carried out, and a detailed response sent to the complainant in writing.

People and their relatives told us they would complain to staff if they needed to and some had given verbal feedback which had been acted upon. Comments included, "Not really anything to complain about", "I haven't got a complaint, not really. I just take it as it comes", "I would just talk to the nurse if I had one", and, "I have complained informally about small things like the food – too much and cold. They put it right." A regular visitor to the home also told us, "They take my feedback seriously and do something about it." This meant people and their relatives felt confident to raise concerns if they needed to, which indicated there was a positive and open culture at the home."

Requires Improvement

Is the service well-led?

Our findings

People and their relatives told us they thought Riverside Court was well managed. Comments included, "It's well run", and, "It appears to be well managed."

The new home manager, who had been in place for two weeks prior to this inspection, told us they had started the process of becoming permanent registered manager for the home. Feedback from staff about them was positive. Comments included, "If I've got a problem I go to [them], [they're] very approachable", "You can go to the manager with suggestions. [They're] reasonable", and, "I think [they're] approachable. I feel optimistic."

At the last inspection in October 2015 we found a breach of the regulation relating to good governance as effective systems were not in place to assess, monitor and improve the quality and safety of the service provided to people who use the service. At this inspection we reviewed the audit arrangements used to drive improvement at the home.

At this inspection we found a range of audits and other quality monitoring was in place. This included regular checks of mattresses, medicines, incidents and accidents, health and safety, weight loss, infection control and the dining experience. Each unit had a file in which various statistics were recorded and analysed each month before being fed to the home manager who had overall oversight. We saw in some cases actions had been identified and resolved, others were ongoing. As discussed earlier in this report, during this inspection we identified breaches of regulation relating to infection control practice, Mental Capacity Act 2005 and Deprivation of Liberty Safeguards compliance and induction records. We also found breaches of regulation in medicines management and accurate record-keeping found at the last inspection in October 2015 were outstanding. This suggested the audit and monitoring in place since the last inspection had not been effective.

When we fed concerns back to the home manager they could evidence they were aware of the problem and had put plans in place to resolve them. This had included a meeting held with the deputy manager and clinical lead to agree roles and responsibilities in terms of care plan audit and improvement, an external audit of medicines, a planned meeting with the pharmacy to improve communication and medicines efficiency, and the appointment of an infection control lead. As the home manager had only been in post for two weeks it was too soon for us to assess their progress with these improvement measures, but we will check at the next inspection.

Records showed representatives of the registered provider had visited the home for monitoring and auditing purposes on several occasions in 2016, although there had been no visits since September 2016. The home manager explained the registered provider had recently reorganised their regional quality team, and new quality and improvement leads were starting in post from 01 April 2017. Part of their role would be to audit homes once every month starting from April 2017. We will also check this at the next inspection.

Audit and monitoring at the home had failed to rectify existing breaches of regulation or prevent further

breaches of regulation from occurring. This was a continuous breach of Regulation 17 (1) and (2) (a) (b) (f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Meetings were held for staff to promote communication across the four units at the home. Each day at 11am the home manager met with the nurse or senior care worker in charge of each unit, the deputy manager, the clinical lead, the activities coordinator, the maintenance worker and the cook. They discussed any accidents and incidents, the activities planned for that day, the day's menu and any other issues that had come up. As described earlier in this report, this forum was used to problem-solve an issue we identified on day one of the inspection with the quality of people's food records. These meetings enhanced communication across the home.

Records showed care staff, kitchen staff and activities coordinators had regular meetings with managers at the home. Care workers told us they could raise issues or make suggestions at these meetings. An anonymous online staff survey was ongoing at the time of this inspection. The home manager said they would receive a report of responses with analysis which would then feed into their action plan for the home.

Regular meetings had also been held for residents and relatives in order to update them about issues at the home and to seek feedback. We saw upcoming meetings were advertised in the foyer alongside a suggestion box and a poster encouraging residents and relatives to speak to the manager or other staff if they had any feedback. Questionnaires had been sent out to relatives in February 2017 and the home manager told us they planned to ask people living at the home to complete them, if they were able, in summer 2017. We saw a 'You said we did' poster in the foyer of the home, which described the increase in staffing levels and provision of activities. This meant people; their relatives and staff could share ideas and make suggestions on how to improve the service and received feedback on action taken by the home in response.

Registered providers have a responsibility to report specific incidents to the Care Quality Commission (CQC). Notifiable incidents include safeguarding concerns, police call-outs and serious injuries. We checked the records for these types of incidents and found they had all been reported appropriately.

Registered providers also have a legal duty under the Health and Social Care Act 2008 (Regulated Activities) (Amendment) Regulations 2015 to display the ratings of CQC inspections prominently in both their care home and on their websites. We saw ratings from the last inspection were clearly displayed in the foyer of the home and on the registered provider's website.

We asked the home manager about the registered provider's vision and values for the service, and how these were communicated to the staff. They explained the registered provider had merged with another healthcare provider and were adopting their vision and values, what they called their 'purpose and behaviours'. As a result, supervision and appraisal documentation, which was based around the registered provider's vision and values, was also changing. This was one way they said the vision and values were communicated to staff as, before their appraisals, staff would be required to self-assess their performance in terms of the vision and values expected. The new behaviours included 'putting people first', 'being a family, and, 'acting with integrity', The home manager also told us, "It's good to be a role model so they (the staff) can see I know what I'm doing and realise the importance of the little things."

We asked the staff why they chose to work at Riverside Court. Comments included, "I love being here. Giving something back and going home at the end of the day knowing I've made a difference", "I get satisfaction from building rapports with people and they know they can trust you", "It's very rewarding. I enjoy talking to the elderly", and, "When I go home I know I have made these people happy. To live life to the full." Feedback

from people and relatives, and our observations (with the exceptions discussed earlier in this report), showed the registered provider's vision and values of care underpinned the majority of care and support provided by staff at the home.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People's privacy and dignity was not respected by staff at all times. Regulation 10 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent The home was not compliant with the Mental Capacity Act 2005. Regulation 11 (1) and (3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Care and treatment was not always provided in a safe way because risks to the health and safety of people were not always assessed and mitigated. Regulation 12 (1) and (2) (a) (b) Medicines were not always managed properly and safely. Regulation 12 (1) and (2) (g) We observed poor practice in infection prevention and control.

Regulation 12 (1) and (2) (h)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Three people were being deprived of their liberty at the home without legal authorisation. Regulation 13 (5)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The registered provider did not always maintain accurate, complete and contemporaneous records in respect of each person. This was an issue identified at the last inspection. Regulation 17 (1) and (2) (c) Audit and monitoring since the last inspection had failed to resolved previous breaches of regulation or prevent those identified at this inspection. Regulation 17 (1) and (2) (a) (b) (f)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The home could not evidence new staff induction and care staff new to health and social care had not been enrolled on the Care Certificate, or equivalent. Regulation 18 (1) and (2)