Speciality Care (UK Lease Homes) Limited

Riverside Court

Inspection report

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Tel: 01977 673233

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Ratings

Overall rating for this service	**Requires improvement**
Is the service safe?	**Requires improvement**
Is the service effective?	**Good**
Is the service caring?	**Good**
Is the service responsive?	**Requires improvement**
Is the service well-led?	**Requires improvement**

Overall summary

This inspection took place on 19 October 2015 and was unannounced.

We previously inspected the service on 28 July 2014 and at that time we found the provider was meeting the regulations we reviewed.

Riverside Court provides accommodation, personal care and nursing care for up to 60 people some of whom have physical disabilities or are living with dementia

The Registered Manager of Riverside Court had left the service in August 2015 and submitted their application to deregister as manager. A peripatetic manager had been managing the service and a new manager was now in post on a temporary basis until a permanent manager could be appointed. A registered manager is a person who has registered with the Care Quality Commission 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.

People we spoke with told us they felt safe at Riverside Court.

Medicines were not always administered or stored in a safe way for people. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Summary of findings

There were not always enough suitably trained staff to meet the assessed needs of people who used the service. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Staff had a good understanding of safeguarding adults from abuse and who to contact if they suspected any abuse.

The provider had effective recruitment and selection procedures in place. Staff had received an induction, supervision, appraisal and specialist training to enable them to provide support to the people who lived at Riverside Court. This ensured they had the knowledge and skills to support the people who lived there.

People's capacity was considered when decisions needed to be made and support provided when necessary to support and enable people to express their views and make certain decisions. This helped to ensure people's rights were protected when decisions needed to be made.

People enjoyed the food and had plenty to eat and drink. A range of healthcare professionals were involved in people's care.

Throughout our inspection we observed staff interacting with people in a caring, friendly, professional manner. Staff were able to clearly describe the steps they would take to ensure the privacy and dignity of the people they cared for was respected and maintained. People were supported to be as independent as possible throughout their daily lives.

People and their representatives were involved in care planning and reviews. Individual needs were assessed and met through the development of personalised care plans. Most people's care plans detailed the care and support they required and included information about peoples likes and dislikes.

Activities were provided at Riverside Court, but this was not at a level which would meet the needs of all the people who used the service.

People told us they knew how to complain and told us staff were always approachable. Comments and complaints people made were responded to appropriately

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. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Accurate records were not always maintained in relation to care that was being delivered. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was an open door policy operated by the manager and deputy manager. People who used the service, staff and visitors had free access to discuss any relevant matters. This helped to create a culture of openness and transparency

The manager held meetings with people who used the service, relatives and staff to gain feedback about the service they provided to people.

Summary of findings

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

There were not always enough suitably trained staff to meet the assessed needs of people who used the service.

Medicines were not always stored in a safe way for people

Staff had a good understanding of safeguarding adults from abuse and identified risks were managed well

Is the service effective?

Good

The service was effective

People's consent to care and treatment was sought in line with legislation and guidance

Staff were provided with training and support to ensure they were able to meet people's needs effectively

People told us they enjoyed the food.

People had access to external health professionals as the need arose

Is the service caring?

Good

The service was caring

People who used the service told us the staff who supported them were caring.

Staff interactions with people were supportive, caring and enabling

People were supported in a way that protected their privacy and dignity.

Is the service responsive?

Requires improvement

The service was not always responsive

People and their representatives were involved in the development and the review of their support plans where possible

Activities were provided but this was not at a level which would meet the needs of all the people who used the service.

People told us they knew how to complain and told us staff were always approachable.

Is the service well-led?

Requires improvement

The service was not always well led

The service's quality assurance systems had not identified the problems we found at the inspection.

Summary of findings

Accurate records were not always kept

The culture was positive, person centred, open and inclusive.

People spoke positively about the deputy manager

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 19 October 2015 and was unannounced.

The inspection team consisted of three adult social care inspectors a specialist advisor experienced in specialist nursing with people living with dementia, and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. Their area of expertise was supporting a family member living with dementia.

Prior to our inspection we reviewed all the information we held about the service. This included information from notifications received from the registered provider, and feedback from the local authority safeguarding and commissioners. Before this visit we had received information of concern about staffing levels at the home and the impact of behavioural incidents

We had not sent the provider a 'Provider Information Return' (PIR) form prior to the inspection. This form enables the provider to submit in advance information about their service to inform the inspection.

We spoke with five people who used the service, nine members of staff, five relatives, the deputy manager and the peripatetic manager. We looked in the bedrooms of nine people who used the service with their permission. We observed how care and support was provided to people. We looked at documents and records that related to people's care, and the management of the service such as staff recruitment and training records, policies and procedures, and quality audits. We looked at six people's care records.

Requires improvement

Is the service safe?

Our findings

Most of the people we spoke with told us they felt safe and visitors we spoke with told us they felt confident their relative was safe at Riverside Court. People who used the service told us, “It is alright." "No grumbles, I am happy here." “I’m very safe in here. I have to have help to get up. They come when I call the bell.” One person who used the service told us they used to be ‘petrified’ as a strange man used to walk into their room at night, but they moved him to another unit. Another person’s relative said the same. We saw from records the service had taken appropriate action to make people safe and provide more supervision and support for the person who used the service who had been entering other people’s rooms. Relatives we spoke with told us if they had any concerns about the way their relative had been treated they would talk to the staff team about it. Relatives said, “Yes (person) is safe, as there are staff around.” "Yes, people are well monitored. (Person) is at risk of falls and staff are aware of this".

We asked people who used the service if there were enough staff on duty at Riverside Court. One person who used the service said, "No definitely not. They are worked to death. I have only just been washed and dressed and it is 10.45am". The person’s relative said the same. Another person who used the service said, “I don’t ask for anything. They never have time. If they had more staff they would be a lot better. They hardly have any staff. They have to be so quick with everything.” Another said, “I would like a shower a day but I can only have two or three a week as they are short staffed".

Two visitors we spoke with felt there were enough staff. One visitor said, "Always when we visit". Another said, "Generally yes". One relative told us, “there is usually one senior carer and one carer on the duty rota on the unit, but as they knew CQC were due a visit they increased it to one senior carer and two carers.” They said some days there was one nurse on duty for 60 people who lived at the home. One member of staff said, “It’s annoying when there are not enough staff.”

We asked the peripatetic manager and the deputy manager how staffing levels were decided for the home. They told us each person was assessed using a dependency tool. If a person’s dependency increased by ten points a care review meeting was held to ensure appropriate resources were in place to meet the person’s needs. Since the last CQC inspection staffing on Shannon Unit had been increased by one carer during the day because of this.

The peripatetic manager told us a minimum of 11 staff members was on duty during the day for 57 people who used the service. Of these two or three would be nurses, therefore eight or nine carers were required every day. The service aimed to have an additional two carers on duty where possible. On the rotas we sampled we saw the minimum number of staff had been achieved and on the majority of dates it was exceeded.

On the day of our inspection there were 12 staff on duty for 57 people who used the service. There were two carers on Clyde Unit for 14 people who were living with dementia and did not require nursing support. The staff told us there were usually three staff on duty, but one carer was sick and one was on escort duty. Two carers and one nurse were on duty on Avon unit for 13 people with nursing needs. Four staff members were on duty on Shannon unit for 15 people with nursing needs who were living with dementia and one nurse and two carers were on duty on Trent unit for 15 people with nursing needs.

The duty rota included on call or reserve members of staff and the contact details of familiar employment agencies in case of staff absence. Reserve staff had been used on the day of our inspection. This showed the service had contingency plans in place to enable it to respond to unexpected changes in staff availability and meant the service to people using it could always be maintained.

One relative told us their relative had not been getting their medicines at the right times and this was very important due to the persons condition. We saw from the professional visit record in the persons file in August 2015 the senior carer on duty had recorded there was a problem with administering medicines at 7am, due to a lack of medicines trained senior carers on duty at that time on the residential unit. The relative informed us the issue had been resolved by reviewing the medicines and changing the time of administration, however they were concerned about the issue of medicines not being able to be administered at certain times of the day if required. The peripatetic manager told us there wasn’t a problem with the nurse on duty on another unit administering medicines to people

Is the service safe?

who used the service on the residential unit and the member of staff had been mistaken. The quality manager told us they would meet with the person and their family to address the concerns.

The peripatetic manager told us a minimum of six staff members were on the night duty rota and at least one of these was a qualified nurse. The service was currently recruiting to a post for a night nurse and a bank nurse was currently covering some night duty. Generally one qualified nurse was on duty at night for around 43 people with nursing needs and 14 other people who used the service. One medicines trained senior carer on the residential unit worked three nights a week and there was no medicines trained senior carer on duty for the other four nights a week. This meant medicines could not be administered on the residential unit at night without calling for the nurse on duty from another unit. The peripatetic manager told us medicines trained senior carers stayed late to do medicines if necessary and another medicines trained senior carer was due to start on the night duty rota in the next few weeks.

The deputy manager told us evening medicines were usually administered before the medicines trained day staff went home at 8pm and the nurse on duty at night was there to cover for any medical emergencies. The quality manager told us if there was an increase in dependency for example: due to illness an extra carer or agency nurse could be agreed by senior managers to provide temporary support. The peripatetic manager told us they aimed for two qualified nurses at night and agreed to review the current arrangements.

During our inspection we observed a homely atmosphere where staff obviously knew people well, however there were not always enough staff available to respond to people who required assistance in a timely manner. During lunch on Trent unit we saw one person who required assistance to eat wait in the dining room from 12.15pm until 1pm to be supported to eat, as the available carer was supporting another person to eat. We saw people who used the service on Clyde Unit seated at the dining table in wheelchairs at 12.10pm and meal service commenced at 12.30pm. One person who used the service commented, “when is dinner coming, bit late this.”

On Avon unit three carers and one nurse were supporting 12 people to eat, nine of whom were in their bedrooms. The third carer had been escorting a person to an appointment that morning and they had been asked to stay that day and help with lunch. Three people commenced lunch in the dining room on Avon unit at 12.25pm supported by two staff members. At 12.50 one person reached for their thickened drink which they were unable to reach on the table. The member of staff told them they would provide it in a minute and continued to support the other person to eat. At 1pm the carer passed the person the drink.

At 2.30 pm there were no care staff present on Avon unit. The cleaner turned the TV up for one person who used the service who shouted out from their room for support. At 4pm we were in the kitchen speaking to the chef when a person who used the service from Avon Unit asked us to assist with their clothing. The chef found a member of care staff.

At 4.15pm we heard a person calling from a bedroom on Avon unit. The inspector looked for a member of staff and none were present on the unit. The person was in bed and unable to get up. They told us they needed help. After around five minutes the inspector found the nurse on duty who spoke with the person and waited for a carer to attend. After a further five minutes the nurse began to support the person with personal care as no care staff attended.

The above issues evidenced a breach of regulation 18 of the Health and Social Care Act (2014) because there were not always enough suitably trained staff to meet the assessed needs of people who used the service.

Appropriate arrangements were not always in place for the management of medicines because people’s medicines were not always stored safely. We saw on Clyde Unit at 13.05pm the medicines trolley was left outside the dining room doors with the keys in the trolley door and the trolley doors open. The carer was in the dining room for approximately one minute with their back to the dining room door. There were two people who used the service mobilising around the unit. The carer then commenced administering medicines in the bedrooms. The carer left the trolley open and unlocked in the corridor whilst administering medicines in the bedrooms with people who used the service. This meant we could not be assured that medicines were stored securely with only authorised care home staff having access to them and that people were safeguarded against access to medication. The peripatetic manager addressed this with the staff member and agreed

Is the service safe?

to review their medicines competency assessment straight away. They told us there had not been any incidents of people who used the service accessing medicines that were not prescribed for them.

Blister packs were used for most medicines at the home. We checked medicines for people and saw that medicines were checked and signed as received by members of staff. We found all of the medicines we checked could be accurately reconciled with the amounts recorded as received and administered, except for one, where one dose appeared to have been missed, which would have had a negligible impact on the person. Two signatures were present on almost all handwritten medication administration records (MAR) charts and a signature list was kept at the front of each MAR Chart Folder. An entry had been hand written on two MAR sheets and only one staff member had signed. On another MAR sheet the staff who had made the entry had not signed the record. This meant there was no evidence to indicate a staff member had checked to ensure the details recorded were accurate. We discussed this with the nurse on duty who agreed to address this.

The above issues evidenced a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The medicines room was spacious and clean with hand washing facilities available. Temperature checks were recorded daily for the rooms where medicines were stored and for the medicines fridge. We looked at the Controlled Drugs cabinet. They were stored appropriately locked within a locked cupboard which was fixed to the wall. The stock tallied and each entry was completed and checked by two staff. The controlled drug records for a transdermal patch for one person recorded the patch had been applied as prescribed, however the topical application record did not tally with the controlled drug record. This meant the records were inconsistent on this occasion. The nurse on duty rectified this. We noted the staff completed a stock check of all the medicines stored in the controlled drug cupboard to ensure that all the stock was accounted for.

PRN (as and when needed) protocols were available for all PRN medications we looked at. A pain assessment tool was used for people who would be unable to express pain and we saw this being used with one person. A PRN protocol provides guidance for staff to ensure these medicines are administered in a safe and consistent manner.

Where people were prescribed topical creams the MAR informed staff to refer to the 'topical application record'. These were retained in people's bedrooms and detailed the name of the cream, where to apply it and when. Staff recorded on the form when they had applied the cream. This meant the records accurately reflected when creams were applied to people and by whom.

The manager told us senior carers at the home completed training in safe administration of medicines every year and we saw certificates to confirm this. We saw nurses and senior carers completed medicines competence assessment annually. This meant people received their medicines from people who had the appropriate knowledge and skills.

The manager had a good understanding of safeguarding adults from abuse and the procedures to follow to keep people safe. Staff told us they had received training in safeguarding and they were able to tell us what they would do if they had any concerns. One staff member said, 'I would report to the nurse on duty, then she would go to the deputy manager or home manager or she would notify safeguarding and management." This showed that staff were aware of how to raise concerns about possible harm or abuse and recognised their personal responsibilities for safeguarding people using the service.

We saw safeguarding incidents had been responded to appropriately and action taken to keep people who used the service safe. We saw the home had a safeguarding policy which had been reviewed and signed as read by staff in and was visible around the home. This demonstrated the home had robust procedures in place for identifying and following up allegations of abuse, and staff demonstrated knowledge of the procedures to follow.

Staff gave us a description of the different types of abuse they may come across in their work. One staff member told us about a recent incident that had been reported to safeguarding. 'A resident walking along the corridor shoved another resident out of the way'. Staff told us incidents between people who use the service could usually be prevented. One said, 'We notice or pick up if anything is likely to occur. We know how to distract. We know residents well'. Another said, "We are a continuous team, so we get to know residents well. We know trigger areas and work to keep these to a minimum."

Requires improvement

Is the service safe?

We looked at the care records of people who used the service and saw risk assessments were in place for a range of issues including hydration and nutrition, pressure area care, low mood, moving and handling, mobility and falls. We saw these assessments were reviewed regularly, signed and up to date. We saw appropriate action had been taken to reduce risks, for example where a person was assessed to be at risk of pressure sores a pressure cushion and air flow mattress was in place. The members of staff we spoke with understood people's individual abilities and how to ensure risks were minimised whilst promoting people's independence.

Staff told us they recorded and reported all accidents and people's individual care records were updated as necessary. The peripatetic manager, who was present on the day of our inspection, and staff members were able to describe the procedure to follow and explain to us the action that had been taken following falls and incidents. We saw accidents and incidents were recorded and appropriate action was taken to ensure the safety of people who used the service. For example, staff told us three people on their unit had a door sensor and sensor mat in place to alert staff that they were mobilising which meant staff would attend and reduce the risk of falls. A falls log was present in each person's file, as well as a body map when falls had occurred. We saw the peripatetic manager had analysed accidents and incidents across the service to look for themes and to identify lessons learned. This demonstrated the service was keeping an overview of the safety in the home. However we saw one person's call bell was not in reach and we alerted staff to this.

A series of risk assessments were in place relating to premises and equipment, for example: kitchen safety, water temperatures, use of bedrails, moving and handling equipment, waste disposal and hazardous substances. We saw evidence that servicing and maintenance of equipment such as hoists had been completed regularly and was up to date. This showed the provider had taken steps to provide care in an environment that was adequately maintained and safe.

At 11.30am on Clyde Unit we saw the store cupboard door containing cleaning products, toiletries and disposable razors was open. We observed a cleaning trolley with cleaning materials on top being left in the corridor whilst cleaning staff were in the bedrooms of people who used the service. We informed the manager about the above issues and they took appropriate action.

People who used the service and staff told us they knew what to do in the event of a fire. We saw checks on fire safety equipment were up to date and there was a trained fire marshal on every shift. We saw from records that fire alarm tests and fire door checks had been completed. There was a Personal Emergency Evacuation Plan (PEEP) in place for each person. PEEPs are a record of how each person should be supported if the building needs to be evacuated. This showed that the home had plans in place in the event of an emergency situation.

We saw from staff files that recruitment was robust and all pre-employment checks had been carried out prior to staff working with people. This showed staff had been properly checked to make sure they were suitable and safe to work with people. One member of staff had not had their Disclosure and Barring Service (DBS) check updated since 2009 and the registered provider agreed to review the frequency with which checks were renewed. The DBS has replaced the Criminal Records Bureau (CRB) and Independent Safeguarding Authority (ISA) checks. The DBS helps employers make safer recruitment decisions and prevents unsuitable people from working with vulnerable groups.

Good

Is the service effective?

Our findings

People who used the service told us staff were able to support them well. One person who used the service said, "Yes there are people looking after me. They know what to do". Another said, "We have got carers around and they know what they are doing".

Staff were provided with training and support to ensure they were able to meet people's needs effectively. We saw from staff files that staff had completed induction training before they commenced employment with the service. We saw evidence in staff files and training records that staff regularly undertook training to enhance their ability to carry out their role and to maintain their knowledge and skills which were relevant to the people they supported. The staff we spoke with told us they had completed 'creative minds' and 'distressed reactions' training in order to support people living with dementia. They had also completed online training in topics such as safeguarding, health and safety and the Mental Capacity Act 2005 (MCA). One member of staff told us they had completed stroke awareness training with the stroke nurse. They said, "I prefer that type of training to the online'.

Staff told us they felt supported and they had individual and group supervision, as well as an annual appraisal. Staff told us this was a two way process. One said, "I get the opportunity to get my bits over as well; it's not all one way'. Supervision records showed staff were receiving regular management supervision to monitor their performance and development needs. Staff we spoke with told us staff meetings were not being held very regularly at the moment due to having no permanent manager in place; however we saw meetings had taken place in July and September 2015.

The service had policies in place in relation to the Mental Capacity Act 2005 (MCA). The Mental Capacity Act 2005 (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. Staff at Riverside Court had completed training and had a good understanding of the Mental Capacity Act 2005. One member of staff we spoke with said, 'if a person lacks capacity they can still make everyday decisions, like 'do you want pie or pasta' but not be able to fill in forms etc." Another said the MCA was about, "'residents making choices. We help people make choices'. One member of staff said, "Some people's capacity fluctuates. Residents get choices in everything. Many people in here can make risky choices. People often lack the capacity to understand risk."

We saw in the care records of people who used the service mental capacity assessment and best interest decisions had been recorded in relation to important decisions. A mental capacity assessment and safety risk assessment was present in one person's file regarding their decision to have their bedroom door on the latch, "as others come in my room and I don't like it." In the file of one person who used the service there was a care plan regarding fluctuating capacity. Capacity had been considered and consent had been sought in line with legislation regarding flu vaccinations and photographs been taken.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act 2005 (MCA). The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS) within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. The peripatetic manager told us they had applied for standard DoLs authorisations for 29 people who used the service, following a mental capacity assessment and best interest discussion for each person and we saw in people's care records this was the case. This meant that the human rights of people who used the service were protected and they were not unlawfully restrained.

People at Riverside Court were supported to have sufficient to eat and drink and to maintain a balanced diet. Most people we spoke with told us they enjoyed the food. One person who used the service said the food was, "Beautiful. I like well-done crumpets for breakfast. Friday is fish and chip day and I love chicken nuggets and chips." One person said, "I can't eat their dinners. It's always cold." This person was served a separate meal of their choice in their room every day, which they were happy with.

People who lived at Riverside Court, who were able to do so, told us there was a choice of food. On Trent unit and Shannon Unit no menu was visible and there were no pictures of the food choice for the day. On Avon unit menus were on the table. One person told us the staff asked what

they wanted for lunch from a menu before lunchtime. One member of staff told us they go round with the menu and people pick. On Shannon unit we heard people make choices about their pudding at lunch time. We saw when the menu had changed on Clyde Unit the options were discussed again with people. At lunch time one person who used the service requested an ice lolly and this was brought for them. On all units food was served already plated up, so for example pudding was brought in with custard already on. Dietary notifications were in care files and the staff we spoke with knew about people s tastes and preferences.

Staff asked people where they wanted to sit and they were attentive to the needs of people who used the service. People were asked if they wanted salt and pepper or if they wanted support to cut up their food. We saw one person was prompted to use the correct cutlery.

Lunch on Avon unit was chicken and mushroom pie, potatoes and vegetables. Three people were supported to eat in the dining room. The other nine people on the unit that day ate in their rooms and food was covered to be transported to people's rooms. Staff explained what the food was that was being offered. Soft option foods were well presented so that residents would be able to recognise vegetables and the food appeared more appetising.

On Avon Unit white crockery was used and coloured table clothes which showed up the plates and enabled people who may be visually impaired to more easily locate their meal. On Shannon unit, however we noticed one person having trouble finding their white napkin on the white tablecloth. The plates were also white, which meant people with eyesight or cognitive impairment would have difficulty locating them. We discussed this with the peripatetic manager and they said they would address this. We saw appropriate equipment was in place such as plate guards and feeder cups to promote independence.

We saw people were assisted to eat and drink at their own pace and carers chatted to the person they supported. Carers encouraged people to eat, offering more when people had finished eating. We saw one person being supported to drink in bed and being encouraged to finish the drink. Food and drink was offered to people throughout the day.

People told us where they had special dietary requirements these were catered for. One person who used the service required a gluten free diet and was able to confirm that they received this. The cook had a board in the kitchen detailing any special dietary requirements. Food was fortified and milkshakes were provided for people at risk. We saw in one person's care plan weight had been monitored and action had been taken when weight loss was recorded. A food diary was being kept, including the quantity of food being consumed. The person was referred to a dietician and supplements were being given as prescribed.

People who lived at Riverside Court were supported to access healthcare. One person who used the service said, "Yes they have called a Doctor for me before and I saw a chiropodist last week". Another said, "I haven't felt unwell." A relative told us, "(Person) has had their eyes tested since (person) has been here but never needed to see a Doctor". Staff said people attended healthcare appointments and we saw from people's care records that a range of health professionals were involved. People had accessed services in cases of emergency or when their needs had changed. This had included GP's, hospital consultants, community mental health nurses, speech and language therapists, chiropodists and opticians. This showed people who used the service received additional support when required for meeting their care and treatment needs. Following a health emergency one person's relatives told us the staff had respected their relatives wishes regarding admission to hospital and used community services to support the person and enable them to remain at the service.

People's individual needs were met by the adaptation, design and decoration of the service. We saw suitable equipment was in place to meet the assessed needs of people who used the service for example: profiling beds, pressure relieving cushions, sensor mats and hoists. Dark wood hand rails were in place around the pale cream corridors to support orientation and mobility.

There were clear pictures and signs to indicate the bathroom and communal rooms. We were told the garden on Shannon unit had been improved and was now accessible. The doors on corridors not for people who used the service to use were painted white to blend in with the corridor. People had a sign on their doors with their name on, a knocker and a letter box to promote privacy.

The atmosphere of the home was homely, clean and well maintained with scenic pictures on the walls and newspaper articles about significant events from history

Good

Is the service effective?

such as the fall of the berlin wall and the ascent of Everest. People who used the service had personalised their rooms to their own taste. We saw in one person's file a risk assessment had been created to enable the person to have a glass cabinet in their room containing ornaments and personal items.

Good

Is the service caring?

Our findings

The service was caring. Most people we spoke with told us they liked the staff and we saw there were good relationships between staff and the people who used the service. People who used the service said, "Yes they are caring". ""The girls are all right" "Some of the staff are very nice." Visitors we spoke with said, "Staff are very caring." And, "Yes I think they are very nice". One relative said, "They are really good. Lovely."

Staff we spoke with enjoyed working at the home and supporting people who used the service.

Staff we spoke with had a good knowledge of people's individual needs, their preferences and their personalities and they used this knowledge to engage people in meaningful ways, for example discussing their hobbies during lunch. We saw most of the care files we sampled contained information about the tastes and preferences of people who used the service, including a short personal history of the person. This gave staff a rounded picture of the person and their life and personal history before they went to stay in the home.

Carers told us they generally worked on the same unit for continuity. This meant most of the time people were supported and cared for by staff who knew them. People who used the service were comfortable in the staff presence and there was friendly banter between them. We saw staff gave good explanations to people to help them understand how they were being supported. We saw staff gain consent before providing support, for example when supporting a person to transfer using a hoist. We saw they waited patiently for people to respond and people were not rushed in their interactions.

People were supported to make choices and decisions about their daily lives. We saw one carer assist a person who used the service into the day room and ask what they wanted to watch on the TV. People were asked if they wanted to come to the dining room for lunch and asked if they wanted to listen to some music. The nurse on duty on the Avon unit told us most people chose to eat breakfast in their rooms and they could get up when they wished or stay in bed.

Staff worked in a supportive way with people and we saw examples of kind and caring interaction that was respectful of people's rights and needs. We heard staff speak with people in a kind and caring way whilst supporting them to eat and also when offering a choice of meal and drink.

We saw one person walking down the corridor and a carer walking towards them took them by the hand, chatting to them and accompanied them to the lounge area. We heard one member of staff ask a person 'have you left your glasses in your room?' and they went to fetch them.

Staff promoted people's independence where possible. One relative said, "They encourage (person) to do most things themselves and if (person) can't do it they do it." We saw one member of staff on Shannon Unit involve a person who used the service in folding napkins ready for lunch. They talked about their previous job working in social services 'helping with dinners'.

The members of staff we spoke with were aware of how to promote the dignity and privacy of people who used the service. We saw staff knocked on people's bedroom doors and asked permission to enter. One visitor said, "They close the doors so you don't see personal care". Another said, "Yes they close the curtains and the door when giving personal care."

Requires improvement

Is the service responsive?

Our findings

The service was not always responsive.

The care records we looked at contained care plans in areas such as medication, sensory perception, pressure area care, falls, communication, pain management and low mood. Personal information such as expressing sexuality was also covered. Care plans were reviewed monthly and most of the care plans we sampled were up to date. These reviews monitored whether care records were up to date and reflected people's current needs so that any necessary actions could be identified at an early stage. We saw information in most of the care plans we sampled had been updated to reflect the person's changing needs, for example a change in the support a person needed to transfer.

People and their representatives where appropriate were involved in and supported with planning and making decisions about their care and treatment. One person who used the service told us they were able to make choices about their care and treatment and one person said, "no, not really." Another said, "I just let them do it, they do explain". Relatives told us people were consulted about decisions at Riverside Court. "My (relative) can make her own decisions, but the home did explain about medication changes". Another said, "Yes, they ring if they make any changes".

The staff we spoke with had a good awareness of the support needs and preferences of the people who used the service. Some care files contained a personal history and more detailed information about people's tastes or preferences, for example the name they liked to be called and a sleep care plan said, "I like a cup of tea before bed. I have my own bedding. I like my lamp on." This helped care staff to know what was important to the people they cared for and helped them take account of this information when delivering their care. One person who used the service told us staff put them to bed too early, usually between 7pm and 7.30pm as night staff come on at 8pm. They said, "it makes it a very long night." The peripatetic manager told us they would address this.

Activities were provided at Riverside Court, but this was not at a level which would meet the needs of all the people living at the home. One person who used the service told us activities were not really of any interest as they were in bed all the time. Another said there were no activities. One person said, "This is the most boring place I have ever known. I watch TV all day." One person told us, "I'm missing a lot of aspects of being at home. I like to go out for a pint. They don't take you out." One relative told us they had never seen any activities taking place at the service.

The registered manager told us an activity co-ordinator worked at the home 30 hours a week, Monday to Friday 9.00 till 3pm. The activity coordinator told us there was a 'resident of the day' who they visit and talk to in their room each day. They told us each person had an activity care plan and they had recently organised some holistic therapy and hand massage. The activity coordinator told us they were now based on Shannon unit every afternoon and planned to play 'target games' today. They told us they occasionally took people out. There was an activity board in the foyer which promoted an "Afternoon tea" activity and invited families to attend. We did not see any organised activities on the day of our inspection.

The lounge on Clyde unit contained a box of activities and a book case with jigsaws and books.

One carer on Clyde Unit told us they had done bingo and armchair aerobics with people who used the service in the last week, "I think it's important. They have dementia but you can still activate their brain." Another said, "There are things around the unit for people to do. We do art and bingo. Some people like puzzles. Some people like to go in each other rooms and have tea and biscuits together. The garden has been done now with raised beds. It is secure for people." We saw in one person's care file only one activity had been recorded between 1 October and 19 October 2015 and this had been with the person's relative. Enabling people with dementia to take part in meaningful and enjoyable activities is a key part of 'living well with dementia'.

People who were able to do so and relatives, told us they would feel comfortable raising issues and concerns with any of the staff and they knew how to complain. One person who used the service said, "I have never felt unhappy, but I would tell my (relative)". Another said, "I would tell the staff. I can't think if I have ever had to. I think they would sort it." One relative said, "I would see one of the ladies in the office." Another said, "I would tell the manager but never had to." Another said, "I would tell the manager."

Requires improvement

Is the service responsive?

The service had a complaints procedure which was visible in the home. We saw the complaints records showed where people had raised concerns these were documented and responded to appropriately. One relative we spoke with told us they felt intimidated by a person who used the service when leaving one of the units, as there were no staff around and a person who used the service was trying to exit. They felt visitors should be escorted by staff when leaving if they have the key code in order to avoid confrontation. The peripatetic manager felt visitors could talk to staff when leaving and suggested discussing the issue at the next relatives meetings. The quality manager told us they would also try to resolve the issue by meeting with the person and their family. This demonstrated people's views and experiences were taken into account in the way the service was provided and delivered in relation to their care

Requires improvement

Is the service well-led?

Our findings

There was no registered manager at the time of our inspection. People who used the service and visitors we spoke with felt the home was well managed and the culture of the home was positive. One member of staff told us "The service is improving all the time."

The registered manager of the service had left the service in August 2015 and was in the process of deregistering as manager of the service. A temporary manager was in place and they were on annual leave on the day of our inspection. The peripatetic manager was present in the home two or three days a week and the deputy manager worked five day shifts a week. They told us a new permanent manager had been appointed and they would be shadowing staff over Christmas and would start work the first week of January 2016

There was evidence of internal daily, weekly and monthly quality audits and actions identified showed who was responsible and by which date. Audits included; medication, skin integrity, infection control, care plan evaluations and training. An infection control audit had been completed and we saw the issues identified had been followed up, for example; ordering new pedal bins. We saw a catering audit had been completed and the issues identified had been addressed through performance management processes. More frequent weekly kitchen audits had also been introduced. This demonstrated the management of the organisation were reviewing information to improve quality in the organisation, however some issues had not been picked up by the audit system, such as two signatures not being present on some handwritten MAR charts and one medicine being missed We saw two suction machines in the medicines room. One was dusty and there was no date of last cleaning. The peripatetic manager agreed to rectify this.

Weekly Information was relayed to senior managers regarding audits such as weight loss, pressure ulcers and infections in order to identify any patterns across the service. We saw senior managers visited the service every month. Issues had been identified in the visit record and we saw some of the issues had been addressed, for example, the PEEPs in some peoples file were out of date and these had since been updated. However some of the issue had not, for example; the operations manager quality visit on 17 September had identified an incomplete mental capacity form and this had not been rectified on the day of our inspection 19 October 2015. The managers' report also noted the person's angina care plan was very poor, with not enough information. The peripatetic manager said they would address this. This demonstrated the home had a quality assurance and governance systems in place to improve the quality of the service, however this system had not picked up and addressed the issues we found with safe storage of medicines and keeping accurate records.

The above issues were a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Accurate records were not always maintained in relation to care that was being delivered. Some of the care records we sampled were incomplete or contained minimal information. For example in one person's file there was a blank pre admission assessment and personal history. In one of the care records we sampled there was no information front sheet or photo and a blank personal history. The recreational activities section was also blank. The activity coordinator told us they asked families to complete personal histories with people who used the service, as they had limited time to do this, but some families didn't do this, so they weren't all completed. They asked families to fill in the, "This is my life" section of the file and bring photos. In another care record the pre-admission information was minimal, for example, "Likes bingo and singing." This is important as many of the people who lived at the home had memory impairments and were not always able to communicate their needs or preferences.

A care plan summary form was present in one person's records detailing the persons medical conditions, however we noticed one of the person's medical conditions had been omitted and there was no care plan specifically related to one of their other significant medical conditions. We saw in another person's care plan there was no specific care plan related to two of their significant health conditions or to their medication.

We saw records for the administration of covert medicines for one person. Covert administration of medicines occurs when medicine has been deliberately disguised, usually in food or drink, in order that the person does not realise they are taking it. We saw in the care records a mental capacity assessment and best interest discussion had been recorded regarding this decision. The record of decision

Requires improvement

Is the service well-led?

form was missing important information such as the person's name and date of birth and the date the form was completed. We discussed this with the peripatetic manager and they told us they would address this.

We saw in one person's care records a choking risk assessment dated 7 September 2015 had not been updated following a visit from the GP and referral to SALT team on 15 October 2015 to reflect this change. The staff we spoke with were aware of the changes and the person's care was not affected. We saw a door sensor was in place in one person's bedrooms which was not recorded in the care plan. We asked a member of staff about this and they told us it was to alert staff when other people who used the service might be entering the person's room. This was added to the care plan on the day of our inspection.

The above issues meant people may be at risk of inappropriate care because accurate and appropriate records were not always maintained. This evidenced a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was an open door to the manager's office and people, staff and visitors had free access to discuss any relevant matters. This helped to create a culture of openness and transparency. One member of staff said, "It's a nice home. I enjoy my job." Another said, "I like working here. We have no permanent manager, but any problems we have got the deputy manager". Staff were clear about what was expected of them and who they needed to go to if had any concerns.

We asked the peripatetic manager how they ensured the service was up to date with good practice. They told us the provider had employed a 'dementia coach' to come in to the service to observe practice and suggest strategies for supporting people living with dementia, and we saw these had been implemented. This meant the registered provider was keen to learn from others to ensure the best possible outcomes for people living within the home.

People who used the service, relatives and staff were asked for their views about care and treatment. One person who used the service said they had completed a survey, "Once when I first arrived and I don't know about any resident meetings". Relatives we spoke with told us they had not been asked to complete any feedback or surveys, but two were aware of relatives meetings.

We saw relatives meetings had been held in April and August 2015, but these had been poorly attended. An annual cycle of meetings had been scheduled and posters given to all people who used the service and relatives inviting them of meeting dates, following a visit by the regional manager, where the issue of feedback was raised. Meetings with staff, people who live at the home and their relatives are an important part of the registered provider's responsibility in monitoring the service and coming to an informed view as to the standard of care and treatment.

Staff told us staff meetings were held, but not very often at present due to not having a permanent manager in place. We saw staff meeting minutes from July and September 2015 and topics discussed included infection control, staff sickness, the registered manager retiring, training, liaising with GP's and the action plan from the recent dementia coaching input.

We saw the registered provider had completed a survey with staff who worked for the service. The majority of staff who responded to the survey were satisfied with their job roll and said they were encouraged by management to put forward ideas on how the service could improve. We did not see evidence that staff ideas had been followed up.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment People who used the servive were not protected against unsafe storage or administration of medicines because medicines were not always administered or stored in a safe way for people. Regulation 12 (2) (g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance 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. Regulation 17 (2) (a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The registered person did not always maintain securely an accurate, complete and contemporaneous record in respect of each person who used the service. Regulation 17 (2)(c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing

This section is primarily information for the provider

Action we have told the provider to take

Sufficient numbers of suitably qualified, competent, skilled and experienced staff were not always deployed to meet the needs of people who use the service. Regulation 18 (1)