High Trees Care Limited

River View Care Home

Inspection report

River View
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20 October 2017
24 October 2017
27 October 2017

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

The inspection took place on the 17, 18, 20, 24 and 27 October 2017. On the 19 October we also visited the service to give some specific feedback. The first and last day was unannounced. We had received information of concern from whistle-blowers, families and the local authority that told us there were immediate concerns. The information included concerns about the leadership the service, staffing levels, continence care, medicine management and staff training. Concerns raised by staff had not being addressed in a timely, supportive way and a person had left the building when they were not safe.

Following receiving this information, we carried out a comprehensive inspection and found these concerns to be valid. The first inspection visit was carried out in the evening due to the safety for people in the service. We also found several other concerns which are summarised below.

We had concerns raised about fire safety, we notified the local Fire Safety Officer who attended on the 18 October 2017 and found concerns that have been communicated to the provider. During and following the inspection, we have also contacted the district nursing service, the local GP surgery, the police, the local Environmental Health Officer, Health and Safety Executive and local authority safeguarding department. Not everyone had Personal Emergency Evacuation plans in place. Not all maintenance concerns had been addressed as needed. Not all staff knew how to evacuate people safely in the event of a fire.

The service was registered under this provider on the 5 November 2014. The inspection was inspected on 26 August 2015 and rated Requires Improvement in all key questions and overall. Breaches of regulations in respect of Regulation 9, 12 and 17 were found. Requirement notices were served. The service was re inspected on 21 September 2016. The service was then rated Good in all key questions and overall.

River View Care Home (referred to as 'River View') is registered to accommodate up to 80 older people who may be living with dementia and/or have a sight impairment and physical impairment. People can receive nursing care at the service. On the first day of the inspection, there were 37 people using the service (with one in hospital) and 32 people using the service on the last day, with one person in hospital. River View has four floors but two were currently not being used.

A registered manager is registered for the service but last worked in the service at the end of September 2017. 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. A temporary manager had been placed in the service by the provider. They and the regional manager were at the service daily (Monday to Friday) with duty cover provided over the weekend.

Staff were not always treating people with respect and dignity. Staff were task focused. Although some positive feedback was received, the concerns had raised with us told us people were not in control of their

care, and were not being treated in a way that showed the service was compassionate and caring. This included people at the end of their life. People's religious and cultural needs were not being planned for at the time of the inspection.

People's care was not personalised and people's basic needs were not always being met. People were also not being given the opportunity to have a say about their care on all occasions and where they could not communicate, family were not involved in planning and designing bespoke care.

People's capacity was not assessed in line with the Mental Capacity Act 2005. Decisions had been made in respect of people's care without detailing if this had been in people's best interest. Staff had minimal understanding of the legal processes they were required to follow to respect people's human and legal rights.

People had risk assessments in place but these were out of date, not reflective of the risks they presented and not clearly linked to their care plans. People's risks associated with specific needs to that person were not always in place and guidance was not then available to staff. For example, there were no records for people with diabetes of how staff could identify when their blood sugar was too high or low and what action to take. People experiencing several falls were not being reviewed in a timely way. There was no analysis of incidents including falls to reduce the likelihood of further injury to people.

People's health, nutritional, hydration and care needs were not always met. People's health needs and the support required were not always identified quickly enough to prevent them experiencing further harm. We found one person left in faeces, and others where their hydration status was not clear. Staff did not always notice changes in people's health needs, did not pass on health concerns to ensure people were checked and reviewed by health professionals.

People were not always partners in planning their own care. People's preferences were not always recorded or acted on. People told us they could only have a bath when staff told them. People were also happy that they could have the choice of food they liked.

The administration of medicines was unsafe. We found that when people had medicines prescribed to be taken "when required" that the care plans on how these were to be managed were not complete. We found that a number of people had covert medicines agreements in place. This means that people may be given their medicines disguised in either food or drink. These agreements did not follow either best practice guidance or the provider's own policy. This meant that people may not have their wishes respected about how they wish to take their medicines. We saw that some medicines were left in an unattended area where they were accessible to people who may have a diagnosis of dementia. Medicines requiring refrigeration were not guaranteed to have been kept at the optimum temperature. The application of prescribed creams was not recorded consistently.

Training identified by the provider as mandatory training had not been completed. This included ensuring all staff were up to date with their medicines training and competency checks. For example, in respect of people living with dementia and presenting behaviour that may challenge. This impacted directly on people where staff were required to assess a person in respect of "as required" sedative medicines. The lack of training for staff in dementia care may have contributed to the reasons why staff did not appear to understand the needs of people living with dementia. Also, it failed to ensure a good basic standard of care among all staff new to care. Staff were not being supported to maintain good standards of care through supervision, appraisals and checks on their competency.

Staffing the service safely had been an issue prior to and during the start of the inspection. There had not always been sufficient staff on duty to deliver care safely. People were not protected by staff and systems which would ensure abuse was identified and reported. Staff on duty were not deployed based upon their skills and experience. Nursing staff were frequently called to advice on residential people at the service, rather than the district nursing team.

People were not being supported to be socially stimulated or physically active. Activities were not provided in groups or on a one to one basis. During the first week of the inspection the activities co-ordinator was on annual leave. On the second week the activities co-ordinator provided activities on floor two, however, we did not observe them on floor one until the last day of the inspection. People's links with the community were not maintained. People's religious needs were not being met.

Staff were not always following safe infection control practices to ensure people were protected from the likelihood of cross infection. Floor one smelt of urine on the first two visits which was addressed but the floor remained sticky under foot. However, the provider has advised,
cleaning processes were in place, and the stickiness may have been caused by non-slip safety treatment. We found people were not kept clean and on two occasions found one person nearing the end of their life lying in faeces. One staff member was allocated on some days to work in the laundry and to do the cleaning. They told us they struggled to cope with all that was required in the time available.

We found there had been poor leadership and governance. Poor auditing and a lack of action led to multiple breaches of the regulations. Where concerns had been identified, they had not been acted on. Staff described how they hoped things would now change with the new managers or in the future. Other staff and relatives were wary as they had seen so many managers come and go.

There was a complaints process in place but complaints were not recorded and acted on since the last inspection. Those wishing to raise a concern did not receive the required feedback and resolve.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as

inadequate for any of the five key questions it will no longer be in special measures.

We found breaches of the Regulations. All processes have now been completed and the service is now closed.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People's medicines were not safely managed and administered.

People's risks were not always being identified and mitigated.

People's safety in the event of a fire was not guaranteed.

People were not always protected by ensuring infection control guidance was followed.

Staffing and how staff were organised were not always in place. Records did not demonstrate staff recruitment was following current guidance.

Is the service effective?

Inadequate

The service was not effective.

People were not having their right to consent to their care and treatment respect. Staff were not ensuring they were meeting the requirements of the Mental Capacity Act 2005.

People could be deprived of their liberty as staff were not ensuring they were meeting the requirement to work in the least restrictive way.

People were not guaranteed to have enough to eat and drink.

People's health needs were not being met as staff were not ensuring they acted quick enough to meet their needs.

Is the service caring?

Inadequate

The service was not caring.

People were not guaranteed to be treated with kindness, consideration and compassion.

Staff did not always treat people with dignity and respect.

There was no evidence people had any control over their care.

People's faith needs were not met.

People at their end of life was not always planned for.

Is the service responsive?

Inadequate

The service was not responsive.

People's care was not personalised. Staff did not have access to the basic, up to date information on people needs.

People were not always having their basic care needs met.

People and their representative were not always involved in planning their care.

People were not provided with the activity required to remain active mentally and physically.

Is the service well-led?

Inadequate

The service was not well-wed.

A lack of governance and leadership led to multiple failures of care and staff feeling unsupported.

Audits and checks of quality of care at the service had not ensured people were not subjected to inadequate care.

River View Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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.

The inspection took place on the 17, 18, 20, 24 and 27 October 2017. We also attended on the 19 to give specific feedback on one person. The first and last day were unannounced. This first inspection date was carried out in the evening due to concerns we had about the safety of people in the service.

The inspection team varied across the five days and included three inspectors, a pharmacist 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.

Prior to the inspection we reviewed the information of concern we had from whistle-blowers, families and the local authority that told us there were immediate concerns. From this information, we decided to carry out an inspection. We also reviewed our records such as notifications which are specific events registered people have to tell us about. We also looked at past inspection reports.

During the inspection, we looked at the care of 15 people to ensure they were receiving the necessary care and treatment. We visited all the people and spoke to as many as we could over the days we were there. We spoke with seven visitors who were relatives or friends. We observed how staff interacted with people in the communal areas. This included the use of a SOFI (Short Observational Framework for Inspection) which is a tool to observe the care of people who cannot otherwise communicate with us.

We looked at five staff personnel files, training records and how training, support and supervision was being planned and overseen. We spoke with 10 staff. There was a temporary manager, regional manager and nominated individual who we spoke to as needed for more information.

We reviewed the records used to reflect on the quality of the service and records on maintenance of

equipment and the premises. We requested a questionnaire was given to family and visiting friends and we received five of these back.

During the inspection we spoke with three community nurses, a tutor of further training and two social care workers.

As we had concerns raised about fire safety, we notified the local Fire Safety Officer who attended on the 18 October 2017 and found issues that have been communicated to the provider. During or immediately following the inspection, we have also contacted the district nursing service, the police, the local GP surgery, the local Environmental Health Officer, Health and Safety Executive and local authority safeguarding department.

Inadequate

Is the service safe?

Our findings

At our last inspection in September 2016 we rated this area as Good but at this inspection we had concerns people were not safe and were at risk of harm. People were neglected, their risks not acted upon, medicines were not well managed and safety incidents and concerns were not acted upon in a timely way.

People's risks were not identified and managed well to keep them safe. People had risk assessments in place to highlight risks of malnutrition, skin issues, falls, how they mobilised and the level of dependency on staff. However, people's risks were not incorporated into their care plans. For example, part way through one person's care plan it stated they were diabetic. When we spoke with staff they told us this person had been in hospital and come back without their diabetic medicine. They assumed from this they were no longer diabetic. When we checked this had not been checked. The temporary manager advised they needed to assume they were no diet controlled until this could be checked with GP. This meant key parts of their monitoring by staff, care plan and associated risks were not in place. For example, the higher risks associated with their skin and foot care were not being assessed and planned for. Other people who were diabetic did not have risk assessments in place or the information for staff to identify when a person was hypo or hyper glycaemic. Another person had a chronic condition that could have an impact on their eating and weight it if flared up. When we spoke with staff they were unaware of the implications of this condition. This person was noted as losing weight but there was no recording this pre-existing health condition had been explored as a possible cause. There was no risk assessment in place in respect of the specific health need to ensure staff were aware how this could impact on the person and their weight. This meant staff could miss vital signs of people's health needs and when action needed to be taken.

People's risk of choking had not being monitored to ensure this need was mitigated. Where people had been referred to the SALT (speech and language team) for specialist advice on how to prepare their food and fluids, there was no risk assessment in place that could then be reviewed. Also, staff were not identifying people who were at greater risk of choking when other factors were present such as being supported to eat in bed. For example, one person had been seen by the SALT in April 2017. This assessment stated they should be given "Fork mashable" food via a teaspoon, thickened fluid (syrup), small mouthfuls and staff were to pause to ally them to have time to swallow. Full supervision had to be given. This person was observed to have their food and drink given to them in bed on every occasion. Their posture meant they could be at risk of choking. There was no associated risk assessment and instructions to staff on how to support them to eat safely. Their care plan created 15 September 2017 states, "[They] eats a soft diet as they prefer this". It did not say how this food is to be prepared in line with SALT assessment and made no mention of the position to place this person to prevent issues with choking arising. Their relative told us that they regularly asked staff to ensure they were in a position to eat safely.

People's risk of falls were not being explored to ensure the help, support and advice was in place to mitigate those risks. There was no evidence the registered manager, provider or other staff were ensuring records of people's falls were accurate. No audit had been completed to see if lessons could be learnt or ensure people and the environment were safe. For example, we reviewed one person's care. They had a risk assessment in place with no date which identified they were at risk of falls. There was no further information on their risk

assessment addressing how the risk was to be reduced to prevent a fall. Their care plan had also not been updated as falls had occurred. This person had a fall and sustained an injury on 16 August 2017. We reviewed their care plan dated 1 August 2015. The care plan stated the person was fully mobile, independent and used a stick for walking. However, an undated document signed by the registered manager said they had become increasingly frail and further undated information in their file recorded the person required bed rails, a crash mat and a special bed which changed height. These were provided. Staff told us on 18.10.2017 that the person now required a frame to walk and two staff supporting. This meant records did not keep up with people's needs.

On the 17 October 2017 we met another person who had extensive bruising to both their forearms and an open skin tear on their right elbow. Staff told us they had fallen and were falling often. Their falls risk assessment (last reviewed on the 17 October 2017 and 10 other times since it was created on the 1 November 2016) showed they had gradually moved up the falls risk scale to high risk. Their records also referenced the possibility of many falls taking place but there was no system operating to record and monitor these. Falls were referred to throughout their care records and when we spoke with the district nurse other dates were given to us that were not in their records. Different parts of their care records referred to falls. The last one on the 16 October 2017 stated this had resulted in "sore ribs" and a "pressure mat put in room". There was no recorded evidence in the care records and from speaking to staff that support had been sought from external agencies in respect of this person falling so often. We asked the district nurse if the service had sought their advice. On the 18 October 2017 they confirmed the person had been referred to them following falls which had resulted in skin injuries. However, no referrals had been made to the GP, falls clinic or to the district nurse to seek advice on how to reduce the likelihood of falls.

Another person on the residential unit, had experienced a fall on the 24 October 2017 that had resulted in a head injury needing stitches. A 30 minute observation chart had been put in place following their return from hospital. On the 26 October 2017 they had fallen at night three further times (2.50am; 10.20pm and 11.20pm) and the nurse from the floor above was called on each occasion to review this person. However when we asked if any observational checks had been made beyond visible ones, we were told that this would not happen as they "are a residential service user. This would be for the district nurse service". Checks with the district nurses the same day, confirmed they had not been asked to come and see this person on the 26th. This was despite the second fall at 10.20pm (from the 26 October 2017) had disturbed the head wound. The record stated, "Nurse [at night] said no need to re dress and keep an eye on" the person with 30 minute checks resuming.

Speaking to staff, they were aware this person was a high risk of falls. Their care records held concerns raised by family (with Lasting Power of Attorney for care and welfare) about the person's risk of falling. This was dated 27 July 2017 and requested staff ensure their walking frame was being used to stop the high number of falls that they were finding distressing hearing about. Their care records for falls and mobilising showed that no changes and assessments to their needs have been made between the 4 March 2017 and the 25 October 2017. Their care record of the 25 October requested staff make sure they had their walking stick with them (no mention of a walking frame as mentioned in the communication from family).

On the 17 October we heard one person calling out, "Help me please, help me". Staff walked past this person and did not respond to their needs. We spoke with the person and they told us they felt "awful". We held their hand and asked staff if there was anything, such as a cup of tea, could be got for them. This was brought and the person enjoyed the drink. Two other people were heard to shout out throughout the inspection. Staff spoke about these people in terms of this being "normal" or it is "just X". One of the people involved was heard on the 25 October, while we were completing an observation, to continually berate their life and the purpose of living. The staff did not respond to this at any point although it was loud enough to

be heard by us. The person also periodically rubbed their hands together or made chopping actions on one hand or the other. This action was also not picked up by staff although this behaviour was repetitive. On October 27 2017, they were heard to shout out throughout the day but when we enquired about them staff told us this was normal for this person. Staff did not then reassure them or support them to be able to move on from this behaviour.

Two people were identified by staff to us as being near the end of their life. Neither had care plans in place that detailed how staff were to support their care at this time. One person had "just in case medicines" to support them to be pain free when the time came but when we spoke with the district nurse (who would have nursing responsibility), they were not aware this person was requiring end of life care so were not offering visits to check on them. This meant issues like looking after their skin was not having district nurse oversight.

The other person at the end of their life was seen by inspectors at 6pm on the 17 October 2017. There was a strong odour in the room and we heard them calling, "I want my mummy." We found the person with faeces on their sheets and on their mattress cover. We advised the staff so they could address the situation for the person. When we went to check 30 minutes later the situation had not changed for that person. When we spoke to staff again, they told us they were going on a break. The person remained in soiled sheets until the staff returned from their break. The following day we visited the person again at 1pm. They were in bed as they are at the end of their life. We found the person had faeces on their pillow cover just by their face and their incontinence pad was soiled. When advised, staff promptly changed them. Their associated records on what care and how this was delivered were incomplete. They were eating and drinking very little and nothing was mentioned about mouth care to support them to feel comfortable. Records did not show how staff were to support then when they "shouts out" and who was going to support them at the end of her life.

On the 18 October, we identified a person with a nut allergy. If the person consumed this food, they could be placed at serious risk of harm. Nowhere in their care records was a risk assessment or care plan to identify for staff how to manage this for this person. Also, no provision had been made in the kitchen to prevent cross contamination. When we spoke with the kitchen staff on the morning of the 18 October, we were told no one required their food prepared in line with any food intolerances or allergies and the nominated individual confirmed on the 20 October the kitchen staff had not known about this. We requested immediate action to be taken in respect of this and advised the Environmental Health Officer of the concerns. On the 24 October, we saw an area of the kitchen had been allocated to prepare their food however, other food stuffs were being prepared in this area, staff had not been told about the use of specific gloves and aprons nor had separate equipment been provided. This meant a risk of cross contamination remained.

The management and administration of medicines was not safe. We found that when people had medicines prescribed to be taken "when required" that the care plans on how these were to be managed were not complete. The information about how these were to be used or the condition that they were for was not contained on the MAR chart or within the care plans. The plans only contained information about the condition the medicines were prescribed for and lacked the detail of actions and assessments that need to take place before administration. When these medicines were administered no record was made of how the decision to administer had been taken or the outcome of the administration. This means that people could not be assured that they were receiving these medicines in a safe and effective way.

We found that a number of people had covert medicines agreements in place. This means that people may be given their medicines disguised in either food or drink. These agreements did not follow either best practice guidance or the provider's own policy. For some people the use of covert administration was

described as variable in these agreements. For these people it was not recorded when a medicine had been administered covertly or when a person had taken the medicine with their knowledge. This means that people may not have their wishes respected about how they wish to take their medicines.

For example, one person was prescribed a sedative "as required" (PRN) medicine covertly as they "became agitated and was trying to leave the home". Staff told us this person would not always accept oral medicines. Staff informed us they had received verbal consent and email confirmation from her GP to administer the medicine at the "judgement of staff". However, we found that there was no capacity assessment in place to determine the person's capacity to make decisions and agree to this treatment. There was also no recorded evidence of a best interests meeting to evidence the decision making and no care plan or guidance in place for staff regarding when to administer the PRN and what dose to administer and when. Their medicine administration chart was very hard to read. When we spoke with the nursing staff they were not aware of the legal processes they were required to follow to administer medicine without a person's knowledge.

A relative of another person told us, "[My relative's] agitation and aggressive behaviour; I don't think this is being dealt with in the right manner. Too easy to give them medication. It goes back to different staff not knowing them, what will distract and settle them."

Another relative has raised concerns with us about an "as required" pain relief medicine being given to their loved one, who was living with dementia, without a clear pain management plan in place. The relative questioned why staff thought their relative was in pain and the assessment of this. There was no pain scales or assessment in place. A document from a mental health professional (from June 2016) stated the person was not in pain. There was no recorded evidence at the service staff had requested a review of the person's pain or rationale evident at the inspection to explain the pain relief administered.

The application of skin creams was not clearly recorded to evidence people had these applied as they required to maintain their skin integrity. We were told by staff that people's skin creams were applied by the carers and recorded on daily records. These records were incomplete and variable. For example one person at risk of skin damage had gaps on their topical skin cream chart from 5/9/17 to 8/9/17 and 10/9/17 to 22/9/17. This meant there was no evidence creams had been applied as prescribed. Some of these charts also indicated that the creams were not always available to be applied.

We found that the provider had made arrangements for the safe storage of medicines and that most medicines were stored securely. However, on the 24 October we saw that some medicines were left in an unattended area where they were accessible to people who may have a diagnosis of dementia. The provider had also provided two medicines fridges. For one of these fridges the temperature had not been recorded for 12 out of the preceding 23 days, and the other had not been recorded for 10 out of the preceding 23 days. The records for one of the fridges only recorded the current temperature and not the temperature range as indicated by the provider's policy. This meant the provider could not be assured medicines in the fridge were stored in accordance with the manufacturer's directions. Not storing medicines at the correct temperature may mean they are no longer suitable for use and possibly ineffective.

We were told by the staff running both floors that day, that there was no system in place to monitor sterile equipment stored in the medicines room. We saw that some of the sterile equipment was no longer within the expiry dates specified by the manufacturer. Examples of expiry dates seen are 11/2015, 12/2017, 04/2016, 02/2016, 09/2017. This could mean that people could be exposed to an increased risk of infection. The provider has told us that staff would check the dates and accepted there should have been better stock control.

The provider gave us a copy of their current training plan. Not all staff we observed administering medicines had received current medicine training or had been assessed as currently competent to administer medicines. This meant that people could not be assured that medicines are administered to them in a safe manner. The provider took action to address this issue when it was raised with them.

On the 23 October 2017 the provider had carried out an audit of their medicines arrangements during the period of our inspection. When we checked the audit against our findings we found that they had not identified all the issues related to medicine management that potentially put people at risk. The provider had added their actions following the audit to the "Home Development Plan" but had not put in place immediate actions to address some of the concerns they found. Following feedback the provider gave an assurance that these and our concerns would be addressed. The service had arrangements in place to use Homely Remedies. These are medicines that can be bought over the counter for the treatment of minor illnesses. We found that the medicines being used for this purpose also included medicines that were only available on a prescription and as such should not be used as Homely remedies.

On the evening of the 17 October neither the management team nor staff knew who was in the building. On the first evening we received conflicting numbers of which people were living in the building. Both managers and the staff had different numbers. The staff rota, staff timesheet and who had signed into the building did not match. This meant in the event of a fire, not everyone may have been accounted for.

The premises and people were not guaranteed to be safe. On the 17 and 18 October a side door was constantly left open. This area was not easily observable. The adjacent stairs could then access all areas that only had a 'push button' access. We were told by the temporary manager this was used by staff going on a break. The inspection team had to constantly ask for this to be shut when it was not being used. Also, on the 18 October we saw that visitors were not always signing in. Visiting friends and relatives had the door codes and let themselves in but were not reminded to sign in and out. This meant there was not a clear record of who was in the building.

Visiting contractors and professionals were also not always signing in. Throughout the inspection visiting contractors and professionals were given the internals codes and left to move around the building. No one was taking them to where they needed to go and introducing them to other staff such as the nurses or senior carers. This meant not only was there a potential risk in the event of a fire, but also there was no record of who came and went if there were an incident at the service.
People were not being kept safe in the event of a fire. The fire doors fitted with automatic closures were not always closing fully and some did not stay open so people were sitting behind closed doors. Personal Emergency Evacuation Plan (PEEPs) had not been reviewed and added to since July 2017. This meant new people and changes in need had not been updated so that it was clear what support people needed to evacuate safely. Not all staff had undergone recent fire safety training. Staff were not calling the fire brigade immediately when the fire alarm sounded. One staff member said, "Never had fire training, I'd get everyone out. I don't know what PEEPS are".

A fire risk assessment was carried out by an external contractor on the 16 December 2016 which made several recommendations. There was no evidence of action taken by the provider following these recommendations. The recommendations included addressing the emergency lighting and fire doors. The fire safety officer attended the home on the 18 October 2017 and gave the provider written instruction on meeting the requirement of the fire safety risk assessment, fire safety arrangements, emergency routes and exits, information to staff from outside (such as agency workers and contractors) and training. Another staff member said, "We have reported the fire doors many times".

Monthly internally completed maintenance records showed that a number of emergency lights had been identified as not working from June to October 2017. This had been reported to the registered manager each month. No action had been taken. We spoke to the regional manager about this, who ensured the contractor was contacted so this could be resolved. A date will then be arranged with the fire service to ensure all emergency lightings are in working order.

Infection control measures were not always in place. The floors on Floor one were constantly sticky under foot throughout the inspection. The provider has advised the flooring is wooden and non-slip and there was clear evidence of regular cleaning. The non-slip safety treatment does feel like stickiness. If the floor were to feel completely smooth, then a falls hazard would eventuate especially when wet. The washing was managed with one washing machine as the other was out of action and waiting parts. This meant there was a delay in the laundry. However, the provider advised the times that there was one staff on duty was a rarity. Also, at times there was only one domestic staff on duty responsible for cleaning and laundry duties. Staff told us how this made it difficult to stay on top of the tasks required. There was no cleaning programme for washing the slings and slide sheets. Staff said when they thought they needed cleaning, they took them to the laundry.

One relative told us, "I have noticed a decline in cleanliness. The cleanliness of the place is disgusting at times; hallways you stick too, tables, remote controls sticky. I had to take [my relative's slippers home and wash them as they were revolting; food, hair etc. stuck on them".

This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Concerns regarding staffing of the service was raised with us before and during the inspection. We were told by whistle blowers prior to the inspection that not enough staff were employed and people's needs were not being fully met as a result. Also, concerns were raised with us in respect of the high use of temporary staff. The concerns being that people needed to have a familiar staff team that knew their needs. We found staffing levels were not regularly assessed and monitored to ensure they met people's needs. Staffing levels did not take into account the training, competencies and knowledge required to care for people. Staff were not deployed across the service to safely meet people's needs.

The service was relying on agency staff to fulfil their staffing requirements. This was mentioned by both staff and relatives as an issue. One relative said, "I don't think there's enough staff, there seems to be a lack of continuity." Another said, "Staff are spread too thin; I rarely see the same staff, and there simply is not enough of them. A lot of agency staff are brought in on a one off who don't get to know the patient and no continuity for patients or families". They added, that when there has been an issue, the staff member tells them they were not on duty or working then so are unable to answer their query. A staff member working on Floor one told us they had often, (and on the day we spoke with them), been the only permanent member of staff on duty with two agency staff. This had made it difficult for them to know how best to utilise these temporary staff as however staff were deployed, staff who did not know people's needs would either be working together delivering personal care or making breakfast for people. The provider has advised that despite robust recruitment; due to the geographical area the service has found recruitment a challenge and therefore depend on agency staff to fulfil their staffing requirements. The service does request the same agency staff for continuity of care, but this is not always possible.

There was often one nurse employed to look after six people across both floors and staff took breaks together leaving the units short of staff to meet people's needs. For example, on the 18 October 2017 three staff went on a break together. We spoke with the temporary manager for them to address this which they

advised they would. Staff spoke with us about feeling that Floor two was often seen as a higher priority for staffing than Floor one. We were told staff were often moved from Floor one to Floor two which left this floor short of the provider's agreed total for Floor one. We spoke with new temporary manager about this and they too felt staffing was being skewed to Floor two (nursing) with there not being an understanding of the needs of people on Floor one. On the 27 October we observed this for ourselves when a staff member was moved at lunchtime from Floor one on to Floor two. Floor one being the floor where all but one person needed support to eat or remain engaged with their food due them living with dementia. For example, on the 24 October two people eating their lunch disengaged from their food and ate very little and their food eventually removed.

During the first evening we were concerned there were not enough staff on the Floor one. On this floor there were three staff from 2pm to 8pm with one administering the evening medicines when we arrived at 6.15pm. Fifteen people were living on this floor and seven people required two staff for all their needs and two required two staff for all transfers to ensure this could be managed safely. These staff told us they were struggling to meet people's needs such as ensuring people had enough to drink and to be seen more often than routine set visits. Staff added, that when one staff member was administering medicines, the two others were offering care but did not have enough time to go back and reoffer care in a timely manner if it was refused. We observed staff moved from one task to another and were not able to sit and be with people.

People on Floor one relied on staff to check on them as the majority were unable to use a call bell to summon staff for support and assistance. On the 17 October, two people were shouting for staff; one because they felt ill and one because they had partly fallen out of bed. Staff had been unable to hear the shouts. The inspector heard the shouts and sought staff. They requested the senior staff member who then used the emergency call bell. The staff were unable to respond straight away as they in someone's room giving person care. The inspector sought another staff member respond. It did however mean that staff member had to leave the task they had been doing to meet each of the other needs. The nurse was also called from Floor two to come and assess the person who had partly fallen out of bed. They told us they had left the task they had been completing.

A relative told us, "There is often (on floor one) one senior carer and two carers; sometimes one senior care and one carer" adding, "It all comes down to a lack of staff."

This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We were told by the nominated individual that on the 17 October, the first floor should have had one more carer present.

On the 18 October we requested the provider complete a dependency assessment to demonstrate whether they had enough staff to meet people's needs. The temporary manager and regional manager advised the provider had a dependency tool but this had not been completed for some time. They told us completing the tool demonstrated there were enough staff employed or by the use of agency staff We advised some people had their dependency completed in their records that was lower than was actually was being reflected in our observations. The nominated individual agreed to keep the staffing under review. On the 20 October 2017 the NI told us, "2 nurses, 2 senior care, 6 care assistants plus 3 care assistants 1:1.There are 35 residents, 6 of which are nursing care and 29 residential care" and then on the 25 October 2017, "Staffing levels this week are 2 nurses, 1 senior and 7 care assistants for 31 residents as two are currently in hospital". Sourcing a second nurse was not always possible so a second senior carer was then available to support the

nurses on floor two.

Staff recruitment measures were in place in that everyone had Disclosure and Barring Service (DBS) check in place and references had been sought from previous employers and/or character witnesses. However, the staff personnel records showed that essential information was not always checked at the application and interview stage. Documents such as the application form and interview record were not always signed, dated and checked off to ensure there were no outstanding issues. This meant conflicts between a reference and an applicant's reason for leaving had not been picked up as inconsistent. Also, gaps in an applicant's work history were not always explored and accounted for. One staff's records stated their DBS had come back one year later than they started.

Staff were asked to complete a health questionnaire before they started work. This is to check that all staff, following reasonable adjustments, can perform tasks intrinsic to their role. Where staff had raised health issues, there was no evidence of these being reviewed and a risk assessment being completed. This included allergies, hearing issues and potential impacts on their ability to work safely. We have referred this concern to the Health and Safety Executive. They have passed this to the Environmental Health Officer.

We received mixed views from people and their relatives regarding their safety. People told us, "The staff are always popping in to say hello"; "I feel safe because it's so homely" and, "I don't have to worry about anything". One relative said, "I know my relative is being looked after really well" and another, "Yes, I feel mum is safe. Staff are around and I have also observed good manual handling".

However, four other relatives told us they had serious concerns about the safety of their family member. These were in respect of people living on Floor One (where people living with dementia lived). Two of these relatives told us they worried about their loved ones safety after they left the service. One family member told us they felt their loved one was having falls due to the medicines which were making them tired and lethargic but due to this person living with dementia, they felt driven to walk. The other felt it was difficult to rest as they always had to remind staff of the position they needed to sit in while they ate.

Staff gave us a mixed picture of the level of skill and knowledge on how to identify and report abuse. Some were able to detail this; one staff member because they had the training in their previous employment. One staff member told us they had raised serious concerns with the registered manager about the competency of another staff member. They added, "Nothing came to light" from this and no action taken to follow this up" as when they checked this situation had not been addressed. We spoke with the temporary manager who stated they had identified this and will be carrying out competency checks to be assured this and other staff are safe in their care. Following the inspection the provider explained due to the confidential nature of the issues, they were unable to provide the outcome to the staff member. They have accepted however, the staff member should have been assured the issues had been dealt with. All the staff told us when they had raised concerns these were not addressed. This was concerns about people's safety and areas of the home they thought were unsafe. For example, one staff member said they had put in formal concerns about the fire doors. Another member of staff said in respect of the previous manager, "I have tried to raise concerns. We are not listened to, we're just nothing". This meant there was no action taken to review people's care following incidents. The provider has told us since the inspection, they are seeking to ensure all concerns are addressed in line with their and current guidance.

When we asked staff why they had not spoken out and told others they were not happy, not all staff were aware they could have used an independent whistle blowing line provided by the provider or contact CQC. The provider has assured us they advertised their whistleblowing policy and individual staff had been informed about its presence.

Inadequate

Is the service effective?

Our findings

At our last inspection in September 2016 we rated this area as Good but at this inspection we found the service ineffective. People's care did not achieve good outcomes, promote a good quality of life and was not evidence based. Staff were not trained well and the legal processes in place to protect people's human rights were not followed.

We checked whether the service was working within the principles of the Mental Capacity Act 2005, and whether any conditions on authorisations to deprive a person of their liberty (Deprivation of Liberty Safeguards or DoLS) were being met.

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

We found people's rights in relation to the Mental Capacity Act 2005 were not being adhered to. Staff did not have a thorough knowledge and understanding of the Mental Capacity Act or DoLS. Not all staff had received training in this area.

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 MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). DoLS applications had been made on behalf of people that were awaiting validation by the local DoLS officer. We found the service was not acting in the least restrictive way and making sure decisions about people's care was made in their best interests. Where restrictions were in place for people, they had not been incorporated into care plans and risk assessments. Staff also did not know what these were. DoLS applications were made to restrict people without mental capacity assessments being completed first which meant the legal processes were not being followed.

The five principles of ensuring people were protected by the MCA were not being applied to underpin all acts done and decisions taken in relation to people who lacked the capacity to make their own decisions. For example, one person living with dementia, had decisions made about their care and treatment that restricted or restrained them without ensuring these had been made in their best interests. This person was having medicines to sedate them "as required" but it was not recorded why this medicine was being given and what grounds it could be given. There was no record of alternative care for example distraction or engagement in an activity prior to staff using sedative medicine. Decisions regarding the administration of sedative and covert medicines were being made without following the correct legal processes.

Family told us they had not been consulted in respect of their care and treatment and felt that the service was not ensuring they were being cared for in a way that would reduce their need to have this medicine. That is, "[My relative] has always suffered from claustrophobia, and this has always been pointed out" and, "[They] feel imprisoned now doors are closed through the corridors; [they have] always been an outside

person, walking miles, gardening etc." They added that the medicine was given on two occasions recently when they went to take the person out of the service in case the person "became aggressive". A DoLS had been applied for but there was no mention that this person was being restricted by the use of medicines (sometimes covertly) and equipment such as an alarm mat was being used by staff without the required MCA assessments. The provider states that staff were utilising the mats to alert staff to the person moving because of a high risk of falls and not to restrict the persons mobility. . The person's care plan stated that dementia now prevented their engagement with gardening but no mention was made of any other factors the person themselves would have likely considered if they were making the decisions or acting for themselves.

One person, living with dementia, was having decisions made about their care and treatment that were recorded as a best interests decisions however, there was no evidence their relative with Lasting Power of Attorney for care and welfare had been consulted. When we checked with this relative, they told us their views had never been sought in respect of what was in this person's best interests. For example, they had not been consulted regarding a referral made in respect of how their food should be prepared, a PRN sedative medicine and they were unaware a DoLS had been applied for. They told us also that they felt there was a lack of knowledge about the needs of their relative and how to meet the needs of the person in line with what they would have wished. For example, they had completed a document to describe their loved one was and liked to do before the dementia stopped them being able to say. This had not been included in their planning.

People had alarm mats, mattresses by their beds or bed sides were used. The "consent" forms in respect of the use of bed rails held a GP signature on some of the forms but there was no evidence that a mental capacity assessment had been carried out. There was also no record of who had been consulted in the decision and how this was in the person's best interests

There was no evidence of involvement of external advocates for people who had no one able to act in their best interests. For example, one person had been described as having the ability to consent to their care and treatment in 2014 but MCA assessments had been completed in 2016 and a DoLS applied for. There was no evidence who was acting for them now they were presumed to have lost the ability to consent.

When we observed the care of people on Floor One, we did not see that all staff asked people's consent before offering care. This included giving people their food and drink or one occasion taking the person's unfinished breakfast away.

This is a breach of Regulation 11 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Following our concerns, all DoLS are being reviewed by the local authority as a priority to ensure people were only being deprived of their liberty when it had been legally authorised.

We found the service was not ensuring the least restrictive practice was operating. For example, one person was frequently leaving the home. There was an urgent DoLS in place but this person continued to want to go outside and staff said would become anxious if this need was not met. On 18 October the person expressed they desperately wanted to go out to the shops and was becoming increasingly agitated as staff said they were not able to support this. We suggested the staff seek further advice to support them to visit the shops as the nursing staff had informed us earlier in the day this reduced their anxiety. This person's care plan stated, "Not to go out of Riverview with staff, uncooperative and refuses to return, runs into the road". Staff stated, "She likes to escape", "We have been told to get her away from the doors and lift" and, "She has strong dementia, wandering, 1:1 is due to start tomorrow." There was no risk assessment in place to further

explore the risk they presented outside of the home and how to reduce the risk/s so the person was able to go outside safely.
People's health needs were not always identified in a timely fashion and/or action sought to meet that need. This included the requirement to ensure people had enough to eat and drink.

On the 17 October 2017 we found a person to be heard shouting "help" was found hanging out of bed. Having made them safe, staff called for the nurse on duty to come and assess them. The nurse came and stated they were likely to be suffering from "some dehydration and confusion with a possible UTI (Urinary Tract Infection)". Staff said, "I think [this person] has had a few UTIs since they moved in from February". The person's daily records showed they had a fall in the early hours of the 17th. It was recorded in their daily care records, "06:15 was on the floor – back red, no crash mat/mattress. Pad changed. Crash mat and mattress put in place." Nothing further was then recorded but was handed over to the day shift for 8am. The care plan identified two hourly checks were required, however, staff told us that they thought four hourly checks were required and had not realised this had been changed some time ago to two hourly.

Concerns about this person previously meant they were to be monitored to ensure they had enough to eat and drink and were passing sufficient amounts of urine. These records showed their intake of fluid to be very low and they were not passing urine regularly. They had also eaten little on the 16th and nothing on the 17th. However, staff did not act on the issue they may be dehydrated or had a UTI. On the 17th the inspector requested they consider speaking to the doctor that night. The staff member asked if they should call the out of hours GP service. The inspector advised staff that given the concerns of the person's presentation and the fact they had not drunk enough or eaten, their care needed to be discussed with a doctor. Staff stated they would call and speak to the GP. We found on the 18 October 2017 medical advice had not been sought on the 17th. The person's records continued to be completed as before; with no documentation detailing concerns raised on the 17 October 2017. Staff told us that they had called the GP on the 18th and at 12pm were still awaiting the call back. This demonstrated staff were not identifying people's needs or acting to ensure people's health needs were met in a timely fashion.

This person's family told us, "No, my relative does not have enough to eat and drink" adding, "This is a big issue for me. We were rung to say my [relative] had not eaten for three days. Concerned I went early on Sunday and Saturday to be with them; waiting for lunch to arrive and nothing came. So I went to ask where their lunch was to be told they had asked earlier and they had said no to lunch. I told them no one had been in whilst I was there and that my [relative] felt hungry. They said if we ask and they say no, they don't bother as it's their right to refuse". They then told us staff provided food and the person ate a good amount. Family spoke with senior staff afterwards regarding their concerns about this and were told, "Family should come into feed [your relative] then".

For another person, on August 16 2017 at 5.30am nursing staff from Floor two were called to attend to a person on Floor one who staff had found on the floor in their room. They had experienced a head injury. Records stated this person should have been seen every hour; however no checks were recorded from midnight until they were found on the floor at 5am. The following day, records showed no further checks of this person's welfare or recordings to indicate staff had monitored them closely. The following midnight on the 16 August and early hours of the 17th the person was transferred to hospital. The person had suffered a bleed on the brain resulting in a stroke. No involvement from the out of hours or daytime GP or District Nurse was requested on the 16th when the person's behaviour was noted as have changed.

We heard the same person on the 17 October 2017 shouting from their room "Help me". We spoke with them and they stated they were feeling unwell and they were likely to vomit. We spoke with staff who told us this person can shout out. We advised that it was probably necessary to gauge how they were feeling given their

presentation. The staff member went and spoke kindly to them and reassured them. When we checked their daily care records, it showed they had refused their evening meal that day. However, no further checks were made about this and nothing was mentioned in staff handover so night staff could monitor their health and welfare. Staff spoke of what was "usual" for this person during the inspection saying it was now usual for them to shout out and this had become expected behaviour. Despite the person's history of being ill as above, action was still not taken during the inspection to check the person did not have other health needs.

A health professional told us they felt that the service did not always follow instructions through. They added that they needed to ask more than once for an instruction to be acted on. They felt this was partly down to the high use of temporary staff. We also found staff were not always ensuring that instructions from health professionals were carried through. For example, one person was seen by a dietician on 11 July 2017. There was a list of instructions to support this person to maintain a healthy weight. They had a care plan dated the 2 February 2017 which had no evidence of being updated or added to in July; the next update was not until the 25 October 2017. One of the instructions was to weigh the person weekly and to closely monitor their weight. In July they were weighed on the 31st (with a loss of 1.70kg from June) and subsequent weights were then taken on the 7 August 2017; 18 September 2017 (a total loss of 3.85kg from July) and 16 October 2017 (0.90kg gain). This meant the instructions were not being followed accurately and this person's welfare was not being monitored as required. There was no recorded evidence of actions taken as a result of the identified weight loss at the time.

We observed one relative tell care staff they were worried about their husband's breathing. Care staff said they would inform the nurse on duty. Thirty minutes later, the relative returned again, still concerned about the husbands breathing. We went to get the agency nurse for the relative who had not been informed by care staff of the relative's concerns. The nurse checked the person and provided reassurance to the relative.

This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us, "The food is very good indeed"; "You get plenty of food, it's very good"; "They bring you something else if you don't like what's on the menu"; "The food is on and off, overall it's ok."
Two relatives stated, "The food they serve is absolutely superb" and, "My relative is served pureed meals and they are so well presented, with everything separated."

The GP completed weekly visits to the service. We have communicated with the GP surgery and they are aware of the concerns from the inspection. Their main issue has been around ad hoc ordering of medicines.

Staff were not receiving supervision, annual appraisals and competency checks. Also, they did not have training in essential areas. Along with not all staff having up to date training in medicines and fire safety, we found not all staff had received training in dementia care and looking after people whose behaviour may challenge others. Staff did not know how to support and diffuse people's agitation. This lack of staff skill increased the potential for incidents within the service. Where distraction techniques had been suggested, these were not consistently followed by staff. For example, one person living with dementia had been seen by a mental health worker on 30 June 2016. Staff were given techniques they could use to minimise the person's actions when they were screaming out. This letter identified the situations that may exasperate the situation, such as noisy environments, personal care and when their relative leaves. Also, staff were given instruction to move them to another room, reassure them and engage them in conversation. No further review had been requested but staff and their relative told us the same concerns were apparent. For example, the person was described and observed by us to be shouting out. A care plan also dated the 30 June 2016 makes no mention of the mental health workers suggestions and uses "no apparent reason"

behind the person's reactions; a term referred to by staff going forward. Their relative told us, "I sometimes doubt they have the necessary skills; no one seems to understand dementia. There is a general lack of staff knowing what to do and, how to care for them is virtually nil". When it came to applying the mental health worker's advice, the relative stated as staff did not understand how the dementia was affecting their relative, they were overloading them with complicated questions. For example, when it came to this person spending time out of bed. As a result, they remained isolated and unstimulated. The relative added, "I think they are bored; [my relative] is frustrated" so they shout out.

There was no evidence that staff new to care were being asked to complete a detailed induction. When new staff started, they completed the company's induction on day one. This included the service's policies and procedures. Staff also told us they received training in moving and handling people before they did this themselves. Staff completed "shadow shifts" that is, when they were extra to numbers and could work along staff who knew the service and people. However, one staff member who started to work in February 2017 told us they only shadowed four shifts before they worked on their own adding, "Not too bad for me as I had experience but didn't feel it was enough." They then had a meeting at six months with the registered manager to say they had completed their probation at six months. They told us they'd had not had contact with the registered manager during the six months, nor since. Their other mandatory training had been postponed due to their not being enough staff.

Records of staff training were not immediately available as they had been removed from the system. A recovered copy dated the 24 October 2017 showed us there were significant gaps in the provider's mandatory training. First aid, MCA and DoLS, safeguarding adults and children and handling and moving people was not completed by all staff. Also, no staff had received training in person centred care and only three were listed as having had training in dignity and respect. Caring for people with dementia was not listed although some staff did say the Alzheimer's society had delivered some training a while ago.

This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service was not using the Care Certificate after 2015. The Care Certificate was introduced in April 2015 following the Francis Inquiry to ensure all staff new to care were trained initially to the same level. Although it has not been put into legislation and is therefore not mandatory, it is the benchmark that has been set for the induction of new healthcare assistants and social care support workers and is therefore what we should expect to see as good practice from providers.

When we spoke with the regional and temporary manager, they advised a number of certificates had been located and may mean staff have had more training than is listed. However, gaps were likely to remain. Following the inspection, the provider has made us aware that training in behaviour that may challenge is available. Staff told us they were expected to complete on line training in their own time. However, the provider has advised that staff are expected to complete some online training which complements their face to face training. All staff have an individual log in to access the on-line training or a laptop is available in the home to facilitate this. The training and the time spent to complete each course is paid for by the provider. This online training makes up a small part of the training programme with most being provided onsite by a team of experienced trainers. Staff starting a new course were required to fund these courses themselves or apply for a student loan. Existing courses were funded by the provider.

The nursing staff advised their training was up to date in respect of clinical training and they were satisfied they had the required training to maintain their registration. However, they felt unsupported and there was no evidence of clinical supervision. The provider has advised following the inspection that the nurses had

clinical supervision in August 2017.

Inadequate

Is the service caring?

Our findings

At our last inspection in September 2016 we rated this area as Good. At this inspection we found widespread shortfalls in the caring attitude of staff and people were not always treated with respect.

People were not always responded to in a kind, considerate manner by staff. A lack of consistent staff meant people's needs were not always known. People with complex communication needs did not have their individual needs known or understood. The language used by some staff was not always dignified or respectful. One person was referred to as "an escapee" when talking about their needs. We heard some staff referring to people by their room number, not their name. Some staff did not know people's names. Care staff told us they did not have the time to read people's care plans so they were unable to tell us about people. They provided care based upon a basic handover to them. Care records used language such as "commoded" in respect of having supported people to go to the toilet and "non-compliant" or "compliant" in respect of people behaving in a way that was acceptable/not to staff.

A relative said, "Some [staff] are very kind and speak calmly, but there are a few that would drive me round the bend. "They told us they heard a member off staff trying to do some paperwork talk to someone impatiently; adding "again not enough staff to give attention to these patients". Another relative told us staff had suggested they move their relative when they raised concerns about the poor care.

Another person's care plan was written in a disrespectful manner; written from the perspective of challenging family relationships and negated their diagnosis. A diagnosis which could lead them to be challenging to care for. We requested the NI and temporary manager review this urgently as we saw staff relating to this person negatively by removing them from their lounge and putting them by the staff station on Floor one. We have advised the local authority safeguarding of our concerns about the lack of respect for this person.

People's information was not always kept confidential. The nurse's station on Floor two was centrally located and staffed most of the time so the nurse on duty was readily available. However, that also meant that all conversations with the nurse could be overheard by anyone sitting nearby or by people in the nearest rooms. People, visiting professionals and relatives held personal conversations with the nurse, which were also impossible not to overhear. For example, a visiting professional asked for assistance with someone's bowel treatment. From time to time the nurse left the station for very brief periods. Confidential paperwork was then not locked away. On the 27 November 2017 we noted people's daily care records had been left in the communal areas. This was reported to the temporary manager as staff were not present and were in the lounge. The temporary manager advised they were trialling a new way of ensuring people's daily care records moved with the person and would ensure they were secured in future.

We observed temporary and permanent members of staff struggling to know who people were. One staff member on Floor Two told us, "I don't know this floor – don't know anybody, coming up here is like my first day".

One relative said, "I have peace of mind about my relatives care." However, three visiting family said they were not feeling relaxed that their loved one was being well cared for when they left.

There were no visits by faith leaders and people were not supported to go out into the community to attend local groups. They relied on family to go out. One person's faith requirements to avoid certain foods was respected. However, there was no evidence their faith requirements had been explored in respect of their end of life needs and whether they would want to see religious leader from their faith.

This is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's end of life needs were not always being planned for. Staff told us they tried to ensure there was someone to sit with people at their end of life if they had no family who could do this with them.

All residents we could talk to said they were treated with respect and dignity by all members of staff. One person said, "All the staff are very helpful" and another, "It's the thought outside the care bracket that stands out for me."

One relative told us they felt staff had been kind and compassionate to their relative; making sure they spoke on eye level to them adding, "I can't speak highly enough about [the staff] on the floor, although I do feel sometimes they don't get the support from management."

Inadequate

Is the service responsive?

Our findings

At our last inspection in September 2016 we rated this area as Good. At this inspection we found a task led culture, a lack of individualised care and extremely poor care planning. Care was not responsive to people's needs.

The care plans we reviewed during the inspection lacked sufficient detail and guidance for staff. They were out of date and had not always been updated as people's needs changed. One person's care plan had another name in it. Important information about how to meet people's needs in relation to their health was lacking, for example how to care for people who had mental health needs, diabetes or were vulnerable to skin damage. Care records had some personalised information about people but not all staff had read these so they did not know how people liked their care or needed their care delivered.

Staff told us they relied on shift handover to know what people's current needs were. On Floor two the nurses led this and senior carers did on Floor one. One temporary nurse stated they had been here before and that is how they knew what people's needs were. Handover files (one for each floor) were kept. Each person had a section of their own and the front page of each section held the person's name, status (that is, whether they were residential or nursing funded) and room number together with a photograph. However, we found information relevant to people was not always written down, was out of date and not reflective of people's needs and the handover files on each floor were not kept in a fit state of repair. Both included loose pages that were not named or numbered. Some information had been written on set forms, others were written on blank pages. Dates did not always follow each other. Staff coming back from days off and holiday told us they relied on these files for information about people's current needs. However, it would be hard to identify who the unnamed pages belonged to should the file be dropped. This meant people's current needs were not always available for staff to view. This was shown to management so this could be addressed immediately and a new system was put in place by the 27 October 2017.

People were not involved in care planning by staff. Nurses and senior carers wrote the care plans. Staff, other than senior carers and nurses, told us they never read people's care plans. One member of staff said, "There is no expectation for me to read the care plan" and others said they could but did not have the time. One family member who has Lasting Power of Attorney for Care and Welfare stated they were aware their loved one had a care plan, "but I have not been involved in care plan updating and changes." Another relative told us, they were also not involved in designing and giving information for the care plan adding, "We make suggestions sometimes, but whether they listen is another thing." Staff we spoke with did not know the details about people to deliver care tailored to their needs and did not understand the rationale behind the tasks they were told to complete. They did not question when instructions changed for example, frequency of repositioning.

The care records we viewed did not give staff the guidance to deliver personalised care or the correct treatment to meet their needs. People's life history had not always been sought and where it was available, it was not built into their care plan. For example, one person's care records held their history drawn up by their relative. It told us how they had been involved in their local community and the roles they had. They

were sociable before their dementia stopped this. This person was isolated in their room and very seldom was supported to mix with others. Records, family and staff confirmed they spent an afternoon in the lounge on the 26 October 2017, which was described by staff and their relative as something they enjoyed.

People's needs were not always responded to in order to ensure their basic needs were met. On the 20 October 2017, one person on Floor two had excessively long fingernails which were very dirty. The person also appeared to be very uncomfortable and their call bell was hanging on the wall and out of reach. Staff explained that the person resists having their fingernails attended to and that the person thought staff could not cut fingernails. When we returned later we saw that the nails had been cleaned. The person had been repositioned and the call bell was in reach. Their care plan said they should be turned every two hours but their daily care records stated they needed to be turned every three hours. One staff had not recorded this change and agreed that it was confusing having the two different times for turning and said that they would rectify the file. They would also ensure staff were clear on what was needed.

A family member of another person told us, "My [relative] often has other people's clothes on even though we have labelled theirs. Three times in the past two weeks they have had no glasses on. When we asked staff where they were, they told us they must have left them somewhere. We found them on their bedside table." On another occasion, "Their glasses had been left on a hospital visit with their shoes and no one had noticed for four days." Then added that their clothes were not ironed and their personal care had not ensured they were shaved.

One staff member said, "We give the best care possible but things have been missed because we short staffed" adding, this meant people were not repositioned.

People were not provided with activity or engagement that was personalised or supported them to remain active and stimulated. An activity coordinator was employed but we did not see them on Floor One until the last day of the inspection. Prior to this staff told us, female residents on Floor one occasionally had their nails painted with little other activity taking place. One person on Floor one was identified to us by a visitor that they trained as a classical musician and sang in choirs. We engaged them in talking about this and despite them living with advanced dementia, they could connect with us in short bursts. However, we saw them sitting with a pop channel on the TV or in silence. Their visitor told us, "[My friend] seems a bit lost here; not enough stimulation. There is no engagement with [them] before the dementia. They were "is" sociable but I don't see that happening for them."

A relative told us, "Everyone seems to be sat in their rooms [on Floor one], in bed, in the chair with a telly on, very rarely see any activities going on and only seen [my relative] in with people once and not participating" adding, "I have got more and more upset when I leave [my relative] after each visit, as it feels they are just left to wander. Staff normally say put them by the nurse's station, but it's sad finding them there alone every time. I've never seen them sat in the lounge with a member of staff that has time to sit with them and talk; and that's all that they need sometimes".

Interactions between staff and people were task related. When a task did not need doing, there was little interaction with people. Staff told us they wanted to have more time to be with people but this was not possible due to the demands and their feeling there were not enough staff. On the 18 October 2017 on Floor One the morning shift centred on delivering personal care, breakfast and morning drinks. In between these actions nothing happened for people until lunch. People were left sat in wheelchairs at the table and people were not supported to ensure they had eaten or drank. People were not transferred to comfortable chairs suitable for their needs. We fed back our concerns the temporary manager and regional manager however, on the 20 October 2017 we saw nothing had changed. On the 20th the inspector asked if there was anything

people could be given to support them to have some stimulation. Staff said, "We are doing personal care and will be back to do drinks soon." After some insistence on behalf of the inspector staff brought a cuddly toy for one person who cuddled this and some games that other people could use.

We completed SOFIs (which is an observation tool to use with people who cannot tell us their views) on the 25 October 2017. The main finding, from our observations on Floor one, was staff were only interacting with people when there was a task to be completed. We saw those interactions were largely positive (including administering medicines) however, people were being given drinks off a list with no interaction or engaging them. "There's your drink" was one comment when the drink was put down in front of a person. Also on Floor one, people were noted to be passively watching or falling asleep. Staff came and went from the room and walked passed people without speaking to them. One agency staff member attempted to engage with people but was soon passively sitting by one person with no interaction; this person had their cooked breakfast in front of them for the entire hour we conducted the SOFI (but it was there before). The person ate little and there was very little support for them to remain engaged with their food. People were brought to the room and left at the table with little or no communication from the staff member that brought them or the one in the dining room (that also came and went from the room). On Floor two, during lunch, only one member of staff spoke to people by name when they gave them their food. Other people were called terms of endearment. The interaction when staff put the meal in front of each person was personalised but then there was no more communication. People were sat in absolute silence staring off into the distance while staff moved onto the next task.

Staff said, "Activities could be improved; these are not person centred for everyone", "We try to spend quality time with people but admittedly this hasn't been often. Today (27th) we have been able to; it has always depended on staffing" and, the activity co-ordinator "normally ends up helping out with care so other staff can have their breaks; hopefully we can improve. We have been tasked focused; we need consistency of staff first."

This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

On the last day of the inspection on Floor one; we saw that people were beginning to be taken into the lounge that had not been used the previous days. People were now being supported to sit in comfortable chairs and the activity co-ordinator spent some time with them. Staff said some local volunteers came on a Wednesday to do some simple exercises.

The provider had a complaints policy and we were told some relatives had raised complaints and concerns about care and treatment and about issues around the home such as laundry not being returned. However, no records had been kept of any complaints since the last inspection. No analysis could therefore take place to look for trends and no learning followed to improve the service. Relatives told us they did not receive a response to their concerns.

One relative said, "I don't think such a [complaint process] exists. My complaints to the [previous] manager were not dealt with in a satisfactory manner. I was never briefed as to how they were to be resolved or whether they were in fact resolved. Raising less contentious or demanding complaints with [other staff] is never completely satisfactory". Another relative told us they mentioned to staff when their relative's laundry was missing, adding, "Staff go and look, but nothing comes back".

Inadequate

Is the service well-led?

Our findings

At our last inspection in September 2016 we rated this area as Good. At this inspection we found significant shortfalls in the way the service was led. Leadership was weak, inconsistent and ineffective. Outcomes for people were poor. Governance processes in place at the time of the inspection were inadequate and had failed to improve the quality of care provided to people. .

River View is run by High Trees Care Ltd. A nominated individual was employed which is someone appointed to act on behalf of the provider.

Before the inspection, we had received information of concern about the management of the service. The registered manger had ceased to work at the service at the end of September 2017. Since their departure two interim managers had been at the service. At the time of the inspection the current temporary manager had been in post for 24 hours.

At this inspection we identified multiple failings. We found multiple breaches of regulations relating to keeping people safe, medicine management, staff training and support, fire safety, caring for people in a dignified way and record keeping. We were also told by the regional manager the company had been running at a financial loss for the previous three years.

Staff shared with us, serious issues started to arise for them from about January 2017. Some families have however stated they had been concerned for longer. One staff member said, "From March 2017; things started to change. Not enough of this and that (such as continence pads for people) and understaffed with lots of agency staff. People became stressed with not having enough staff and, staff were getting snappy with each other. The atmosphere went downhill."

Family and staff told us they rarely saw the provider or senior management. The registered manager was seldom seen "on the floor". When the regional manager and interim manager showed us around the service, staff on duty that day, told us they had never met them previously. A comment from family of a person living with dementia stated, "Two issues have not been satisfactorily addressed: the lack of professional dementia training and adequate management and monitoring of that training on an ongoing basis and, insufficient staff" and, "Management, nurses and carers all [demonstrated] indifferent attitudes to this." And another relative said, "We have not had a lot of dealing with the front office, but when we do we have found them not that friendly" adding, that when they have phoned to speak to managers, the phone has not always been answered.

The nominated individual told us the provider had a system of governance and quality assurance to identify when the service was not meeting requirements. On inspection we requested a copy of the provider's timetable of audits or similar from the temporary manager and operations manager. This would have told us what audits and other checks should be completed, how often and when. We were not been provided with this. This meant were unable to gauge if the service was being reviewed in line with the provider's own expectations.

We spoke with the Nominated Individual about what had gone wrong with oversight at River View and they advised their auditing and checking tools had not identified the concerns the inspection and recent feedback from the temporary manager. They were going to go away and investigate why this had happened. Following the inspection, the provider has advised us that prior to the inspection, they had placed the service in 'special measures' in line with their own policy and guidelines.

Throughout 2017 (January to September) audits of the quality of the service were made by visiting staff employed on behalf of the provider. Each of these audits highlighted concerns. For example, audits from January onwards raised issues about staff absence, low staff training numbers, people's care records, unsafe medicine practices, complaints not being recorded, first impressions of the service being poor and people's experiences not meeting expected standards. Actions required arising from these audits were not then taken by the registered manager. Other staff in the service told us they did not feel they could escalate their concerns where they had them. One staff member told us they had tried to do this locally via the use of incident reports that they now know were not carried forward by the previous manager.

Prior to the week of the 16 October 2017, records had not been maintained to record and track incidents, accidents and safeguarding concerns so it was not possible for the new management and us to know what had or not been acted on. That is, they could not tell us what had or not been passed on to the local authority and CQC. We were able to review our records and advise on what CQC had or not been told about. Also, we were told by senior management that previous records relating to all aspects of the running and monitoring the service locally had been wiped from the computer system by the previous registered manager. As much as possible had been retrieved from the provider's back up system by the end of the inspection, however, no one could be sure what had been lost. Only current issues and the findings of the inspection could be reflected on to ensure learning from incidents was available and people protected as a result.

Staff and family had not felt comfortable making suggestions about how the home could be run better. Family members told us they could not remember the last time there had been a residents' and family meeting. No one could recall having recently been asked to give their view on aspects of the service formally by the use of questionnaires on any other means.

Maintenance records were kept however, as identified in the safe section of this report, action was not always taken to ensure any issues were addressed.

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

We discussed our initial concerns with the provider and with the Nominated Individual, at regular intervals following the first day of the inspection. We asked them to review staffing levels urgently. We also raised multiple safeguarding concerns with the local authority regarding people who lived at Riverview.

Audits completed from the 19-24 October 2017, completed followed the start of our inspection, identified in greater detail the issues we were also finding on inspection. A "First Impressions Audit" completed on the 24 October 2017 stated, "All areas in the home require improvement." The first impressions audit looked at environmental and the general look of the home, It was not an overall home audit.

Staff told us, "I am hopeful with [the temporary manager] being here that things will change"; "Staffing has been better since [they] have been here; they seem really supportive. I feel I can go to them"; "[the temporary manager] is doing alright in the last couple of weeks; since [they] have come it feels more

hopeful" and, "[The temporary manager and regional manager] are more approachable. I feel more hopeful for the residents and staff."

During the inspection we checked the service was submitting notifications to us as required. The temporary manager identified gaps where the previous registered manager had not let us know about events they were required to. These notifications were submitted as soon as it was recognised they had not been sent to us.

We asked the temporary manager how the Duty of Candour (DoC) was operating in the service. The DoC states that providers are required to act in an open and transparent manner when responding to a notifiable safety incident. This includes as soon as reasonable practical making essential communications with those relevant and giving an apology if necessary. We raised that the provider may need to reflect on the concerns raised in the inspection in line with the DoC.
Given the overall issue with records, the temporary manager advised they would review the issues they were aware of and ensure the DoC is addressed going forward in line with company policy.