Rivington View Limited

Rivington View Nursing Home

Inspection report

Rivington View
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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

We carried out an unannounced inspection of Rivington View Nursing Home on 19 and 20 December 2016. We last inspected the service on 24 and 25 June 2015 when we found two breaches of regulations; these were in relation to Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Person-centred Care and Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Staffing. At this inspection we found that improvements had been made to meet the relevant requirements previously identified at the last inspection.

Rivington View is a two storey purpose built home that provides nursing and personal care for up to 33 people. The home is situated in the centre of Horwich, Bolton and is close to bus routes, shops and other local amenities. The home has various communal and quiet sitting rooms and provides accommodation in single rooms. At the time of the inspection 31 people were using the service.

There was no registered manager in post. 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.

Since the date of the last inspection the registered manager had taken up a different post within the home and another person had been recruited as registered manager but had not fully completed the process of registering with CQC. Due to a change in circumstances they were unable to continue in the role and left the home in August 2016.The provider told us it had been difficult attracting candidates for the role in the past and they intended to review the job package on offer with a view to making it more attractive to potential candidates.

People living at the home said they felt safe.

We looked at six staff personnel files and there was evidence of robust recruitment procedures in place. At the last inspection on 24 and 25 June 2015 we found the service had failed to ensure there were sufficient numbers of staff deployed in all areas of the building to meet the needs of the people using the service and there was no formal process of assessing people's dependency levels. At this inspection we saw that improvements had been made to meet the relevant requirements of this regulation.

We looked at the staff rotas for October and November 2016 and these demonstrated that there were sufficient care staff on duty to meet the needs of people using the service. Since the date of the last inspection the service had introduced a formal dependency tool which was endorsed by the Department of Health.

There was an up to date safeguarding policy in place, which referenced legislation and local protocols. The home had a whistleblowing policy in place and this told staff what action to take if they had any concerns.

The staff we spoke with had a good understanding of safeguarding, abuse and how they would report concerns.

We saw people had risk assessments in their care plans in relation to areas including falls, pressure sores, and malnutrition. This meant staff had access to a range of information regarding how to manage people's conditions safely.

The home was adequately maintained and we saw evidence recorded for the servicing and maintenance of equipment used within the home to ensure it was safe to use.

Monthly infection control audits were in place. There was an up to date fire policy and procedure. Fire safety and fire risk assessments were in place and fire evacuation drills were carried out regularly. This meant that in the event of the need to quickly evacuate the building staff and people who used the service were familiar with the actions required to do this safely.

Medicines were managed safely. Records of medicines administration (MAR's) had been completed consistently and accurately. We saw PRN protocols were in place for these medicines. There were safe systems for ordering, receiving, storage, administration and disposal of medicines. Robust systems for identifying and following up on any errors and omissions to MAR charts were in place and these were audited on a monthly basis.

People told us they felt staff had the sufficient skills, knowledge and training to care for them effectively. Staff training records were in place and staff had completed training in a variety of areas relative to their job role. Staff told us they received an induction when they first started working at the home.

Staff had access to supervision and appraisal as part of their on-going development; however we did not see any evidence of an annual supervision schedule in place.

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. We found that the service was complying with the conditions applied to the authorisations.

Staff were aware of how to seek consent from people before providing care or support and told us they would always ask before providing care.

The people we spoke with told us the food provided at the home was of a good quality. People had nutritional care plans in place and care plans also contained records of visits by other health professionals. The service had achieved a food hygiene rating score (FHRS) of five.

At the last inspection we found the environment was not consistently effective for people living with dementia. At this inspection we found that improvements had been made to the environment to assist people to orientate around the building.

We saw staff showed patience and encouragement when supporting people. The people we spoke with told us staff were kind and caring. Relatives we spoke with were also complimentary about how staff respected people's dignity. Throughout the course of the inspection we heard lots of chatter and laughter between staff and people and there was a positive atmosphere within the home. People who used the service and their relatives told us that staff listened to them and were approachable.

People's care files contained end of life care plans, which documented people's wishes at this stage of life where they had been open to discussing this.

People living at the home told us they received a service that was responsive to their needs and relatives told us they were involved in care planning and reviews. Care plans contained a good level of detail and had a person centred approach.

We saw the home had been responsive in referring people to other services when there were concerns about their health. When people first started living at Rivington View, an initial assessment was undertaken.

At the last inspection we found that the care people received did not consistently meet their needs and reflect their preferences and this was a breach of Regulation 9 (1) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. During the inspection we found that the format of the care plans had been amended and they were more person-centred and the provider was now meeting the requirements of this regulation.

Care plans captured details such as family background, education, spouse/partner details, children, employment, interests, travel and religion and there was an overview of each person's life history. This meant staff had access to a range of information about people's past lives that was important to them. We saw that there were a variety of 'thank you' cards displayed in the home from relatives of people who had used the service.

Visitors were encouraged to provide feedback to the home through questionnaires. There was also a 'suggestions box' in the entrance hallway where people could post comments.

People were able to personalise their own rooms. All rooms inspected had personal family photographs and items relevant to the individual and people could use their own bedding if requested.

There was a system in place to handle and respond to complaints and we saw the home had an appropriate policy and procedure in place, which was up to date.

The home employed an activities co-ordinator. Recent activities had included Christmas decoration making, flower arranging, reminiscence, chatterbox, books, games and flash cards. A hairdresser regularly visited Rivington View. During the course of the inspection, we observed activities taking place in the activities room.

At the last inspection we were concerned that people were left alone in the lounge unsupervised for long periods of time. At this inspection we found that staff were vigilant with people in the lounge area and no-one was left alone for any length of time.

We found the nurses were very approachable and engaging and facilitated our requests throughout the inspection, as did the rest of the staff team.

People who used the service were aware of who was in charge. Relatives of people who used the service also told us they felt the home was well-led.

The service undertook regular audits covering areas such as medicines, care plans, nursing notes, the kitchen, people's rooms, activities, complaints, the overall premises and fire safety. A quality assurance file was in place and contained records of audits that had been carried out. Information was also supplied each

month to the CCG using the NHS Safety Thermometer.

Staff had access to a wide range of policies and procedures. There was a service user guide and statement of purpose in place.

The service worked alongside other professionals and agencies in order to meet people's care requirements where required. Involvement with these services was recorded in care plans and included opticians, social workers, chiropodists, SALT, doctors and NHS health care workers.

The service had a business continuity plan that was recently reviewed in March 2016.

There was an up to date certificate of registration with CQC and insurance certificates on display as required.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Staffing levels were sufficient on the day of the inspection to meet the needs of the people who used the service and there was evidence of robust recruitment procedures.

People we spoke with who lived at Rivington View told us they felt safe.

Records of medicines administration had been completed consistently and accurately. Accidents and incidents were recorded correctly.

Is the service effective?

Good

The service was effective.

The service was complying with the conditions applied to DoLS authorisations.

Staff were aware of how to seek consent from people before providing care or support. People's care plans contained records of visits by other health professionals.

Staff were subject to a formal induction process and probationary period.

Is the service caring?

Good

The service was caring.

Staff spoken to had a good understanding of how to ensure dignity and respect and staff showed patience and encouragement when supporting people.

We heard lots of laughter between staff and people and there was a positive atmosphere within the home.

The service involved people and their families when developing care plans.

Is the service responsive?

Good

The service was responsive.

Care files contained information that covered a range of health and social care support needs.

Each person had a care pathway, an assessment of possible risks and a description of the person's needs for support and treatment.

The home had procedures in place to receive and respond to complaints.

Is the service well-led?

Requires Improvement

The service was not consistently well-led; there was no registered manager in post.

Staff told us they enjoyed their work and that there was a good culture at the home.

We found there were appropriate systems in place to monitor the quality of service.

Team meetings and meetings with relatives did not take place regularly.

Rivington View Nursing Home

Detailed findings

Background to this inspection

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

This inspection took place on 19 and 20 December 2016 and was unannounced. The inspection team consisted of one adult social care inspector.

Before the inspection the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed information we held about the home in the form of notifications received from the service, including safeguarding incidents, deaths and injuries.

During the inspection, we spent time at the office and looked at various documentation including five care files and medication administration records (MARS) and six staff personnel files. We also looked at other documents kept in relation to the running of the home including audits and service and maintenance records.

As part of the inspection we spoke with five people who used the service, five relatives, five care staff members, a kitchen staff member, a domestic staff member, three nurses, the activities coordinator, the proprietor and one professional healthcare visitor. We looked around the home and spent time observing care including observing the lunch time period.

Before our inspection we contacted Bolton local authority commissioning team to find out their experience of the service. The Infection control and prevention team (ICPT) had recently completed an audit of Rivington View and the service had achieved a score of 99% compliance.

Good

Is the service safe?

Our findings

People living at the home said they felt safe. One person said, "Yes, I do." Another person told us, "Yes, very much so, care is unbelievable." A third person commented, "Yes, I am well looked after and protected." The visiting relatives we spoke with also said they felt their family members were safe as a result of the care provided, comments included, "Totally safe here, no concerns," and "Yes, staff look after [my relative] very well," and "Yes very. [My relative] been here for over a year and never had any issues," and "Yes, very well looked after."

We looked at six staff personnel files and found there was evidence of robust recruitment procedures in place. The files included application forms, proof of identity and references. There were Disclosure and Barring Service (DBS) checks undertaken for staff in the files we looked at. A DBS check helps a service to ensure the applicant's suitability to work with vulnerable people.

At the last inspection on 24 and 25 June 2015 we found the service had failed to ensure there were sufficient numbers of staff deployed in all areas of the building to meet the needs of the people using the service and there was no formal process of assessing people's dependency levels. This was a breach of Regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider sent us an action plan identifying the action they had taken to rectify this issue. At this inspection we saw that improvements had been made to meet the relevant requirements of this regulation.

We spoke with people who used the service, staff and visitors about their views on staffing levels and received mixed comments. One person said, "They are very busy. They work hard here but you do have to wait a while." A second person told us, "There's always somebody there if I need someone. Never have to wait too long." A third person commented, "A little bit short, sometimes have to wait for help."

Comments received from relatives regarding staffing levels included, "Staffing is adequate, always someone about when needed," and "The staff that are here are superb, but not enough of them." and "Yes, support is provided straight away. Very responsive to [my relatives] needs," and "When all staff are in yes there are enough, sometimes when it's very busy and [my relative] needs to go the toilet, they can have to wait a while."

We asked staff about this issue and about their opinion of staffing levels. One staff member said, "Always good when I am on, can respond to people quickly." A second staff member told us, "Yes, staffing is fine. We can meet people's needs." Other comments included, "Yes, I think so; we are as quick supporting people as we can be," and "Yes, definitely. Able to respond straight away and get enough time to spend with each person."

We looked at the staff rotas for October and November 2016 and these demonstrated that there were sufficient care staff on duty to meet the needs of people using the service. Since the date of the last inspection the number of care staff on duty during the day had been increased. There were five care staff and one nurse during the day and two care staff and one nurse during the night. An additional staff member

was employed between 8 am and 11am each day to support staff with providing breakfast which meant there was more staff time available to assist people with getting up and people did not have to wait for their breakfast. At the time of the inspection the service was also actively recruiting to another care assistant post meaning there would be six care staff on duty during the day in future, which we saw had also happened on some days in the past. These were supported by a nurse, non-clinical staff, and domestic and kitchen staff.

Since the date of the last inspection the service had introduced a formal dependency tool called 'Nursing and Care Staffing Levels Calculator,' which was endorsed by the Department of Health. By using this tool the service was able to identify individual dependency levels which were cited as being low, medium or high. From this, it was determined how many staffing hours were needed. We saw that based on the calculations, Rivington View was providing more care staff hours than the tool recommended.

The nurse told us that the service always provided a level of staffing that was above the recognised safe staffing levels identified in the guidance used, and if a staff member was not available during a scheduled shift they were always replaced. We looked at rotas to verify this.

On arrival at the home we observed people gradually getting up and eating breakfast. Staff were visible and brought each person's breakfast to them as they entered the dining room which meant that they did not have to wait long.

We looked at the systems in place to safeguard people from abuse. There was an up to date safeguarding policy in place, which referenced legislation and local protocols. The home had a whistleblowing policy in place and this told staff what action to take if they had any concerns.

The staff we spoke with had a good understanding of safeguarding, abuse and how they would report concerns. One member of staff said, "Yes, I've done training in this. I would ensure the resident is okay and then report to the nurse in charge." Other comments received included, "Yes, I have done this training. I would report any concerns to the nurse in charge," and "Yes I know all about abuse and what to look for; I would tell the nurse straight away," and "Yes, I would tell the manager straight away. Abuse can be people's attitudes, or unexplained bruises, things like that."

We saw people had risk assessments in their care plans in relation to areas including falls, pressure sores, and malnutrition. Accidents and incidents were recorded correctly and included a record of the accident or incident, a summary chart and action plan. We checked historical accident records and found that they had been appropriately completed and included a body map identifying the area of injury (where applicable) and the action to be taken to reduce the potential for further injury in the future. Falls were tracked monthly and information was shared with the Clinical Commissioning Group (CCG).

During the inspection we looked around the premises. The home was adequately maintained and we saw evidence recorded for the servicing and maintenance of equipment used within the home to ensure it was safe to use. Comprehensive records were in place and up to date regarding the safe management of the premises and these were recorded in separate. Historical maintenance records were also held.

We looked at how the service managed the control of infectious diseases. We saw that monthly infection control audits were in place and included areas such as furniture, bedrooms and the general environment and equipment. Personal protective equipment (such as gloves and aprons) were available throughout the home. Cleaning schedules were in place and up to date. The service had achieved a score of 99% compliance in a recent external audit carried out by the community infection prevention and control team in December 2016.

Staff were aware of precautions to take to help prevent the spread of infection. For example, staff said they would wash their hands regularly and use different coloured cleaning cloths for different areas of the home. There was an infection control policy and procedure in place that identified to staff what actions to take to minimise the potential for an infectious outbreak and the action to be taken in the event of an outbreak. Guidance on reducing the potential for the spread of infections was also posted in bathrooms and toilets and in the staff room.

The premises were clean throughout and free from any malodours and different cleaning schedules were in place, depending on the task required. We saw that bathrooms and toilets had been fitted with aids and adaptations to assist people with limited mobility. We saw that liquid soap and paper towels were available in all bathrooms and toilets. The bathrooms were well kept and surfaces were clean and clutter free and the home was clean throughout. Cleaning products were stored safely and Control of Substances Hazardous to Health (COSHH) forms were in place for all the cleaning products in use. The kitchen staff followed a cleaning schedule which was done daily, weekly, monthly or quarterly depending on the task.

There was an up to date a fire policy and procedure. Fire safety and fire risk assessments were in place and fire evacuation drills were carried out regularly and staff attendance recorded to ensure all staff undertook regular drills. People had an individual risk assessment regarding their mobility support needs in the event of the need to evacuate the building and a personal emergency evacuation plan (PEEP). Tests of the fire system were made regularly and the servicing of related equipment, such as fire extinguishers was up to date.

We looked at how the service managed the administration of medicines and looked at medication administration records (MARs) for people who used the service. Staff who administered medicines had all completed appropriate training in the safe handling of medicines.

Records of medicines administration (MAR's) had been completed consistently and accurately. We saw requirements relating to controlled drugs were being met. For example, we saw there were two signatures when controlled drugs were administered, which were stored in a separate, locked room in a safe. Controlled drugs are certain medicines that are subject to additional legal controls in relation to their storage, administration and disposal.

We saw some people were prescribed medicines 'when required' (PRN). We saw PRN protocols were in place for these medicines. PRN protocols provide details about when such medicines should be given. People had medication care plans in place which included their photograph to assist staff with accuracy of administration, GP details, details of currently prescribed medicines, if a specific eating regime was in place such as a soft diet, daily nutritional intake charts, and a MAR chart.

We saw that the staff member who was administering medicines made correct entries on the Medication Administration record (MAR) charts immediately after the medicine had been taken.

There were safe systems for ordering, receiving, storage, administration and disposal of medicines. There was a fridge in which certain medicines were stored. Fridge temperatures were taken twice daily and were up to date and the fridge was clean. There was an appropriate locked room for storing medicines and medicines cabinets were locked and secured to the wall as required. Robust systems for identifying and following up on any errors and omissions to MAR charts were in place and these were audited on a monthly basis.

Good

Is the service effective?

Our findings

People told us they felt staff had the sufficient skills, knowledge and training to care for them effectively. One person said, "Yes, they know what they are doing with me." A second person told us, "Oh yes, absolutely." A third person commented, "Yes, they do. They are very good."

We asked relatives about their views on staff competency. One relative said, "Oh yes, they know what they are doing. The newer ones, they stick to them like glue until they know what to do." A second relative told us, "Yes, no faults with this." A third relative commented "Yes, no problem, all very good." A fourth relative told us, "Yes, they know what they are doing."

Staff training records were in place and staff had completed training in a variety of other areas relative to their job role, such as food hygiene, dementia, infection control, fire safety, first aid and medicines safe handling and awareness. Training was aligned with the requirements of the Care Certificate and Skills for Care Common Induction standards. Staff told us they had received training in safeguarding. We verified staff training information by looking at and cross-referencing training records and certificates.

Staff told us they received an induction when they first started working at the home which gave them a good introduction to working in a care environment. The staff we spoke with said they received sufficient training to help them undertake their role effectively.

One member of staff said, "Training is good. We do practical training here not e-learning." A second staff member told us, "I did all the training before starting the job, did this over a few months, there was about 15 different courses, provided a good starting point." A third staff member commented, "I did a month's worth of training before starting, taught me enough to do the role." A fourth staff member said, "If you want to do more training you can do, and just need to ask."

Staff told us they had received training in using hoisting equipment. Comments included, "Yes, I have done manual handling training. I also have an NVQ Level 3 in palliative care," and "Yes I've been trained in this," and "Yes I've done my manual handling training," and "Done manual handling, done the in-house hoist training and doing my certificate this in January."

We looked at staff supervision and appraisal information. Staff had access to supervision and appraisal as part of their on-going development; however we did not see any evidence of an annual supervision schedule in place. Annual appraisals had either taken place or where scheduled for after the date of the inspection and supervision sessions for care staff were conducted by the nurse. Staff were able to prepare for their annual appraisal using a 'preparation for appraisal' form. We received mixed comments from staff regarding the frequency of supervision. One member of staff said, "Yes, every three months and an appraisal yearly." A second staff member told us, "No, I don't really have meetings but can talk to the nurse if I need to." A third staff member commented, "No we don't have these but can chat whenever we need to."

We looked at notes from previous staff supervision sessions and noted that discussions included

attendance, punctuality, quality of work, team spirit, professional conduct, safeguarding, MCA/DoLS, communication and empathy with residents.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

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 and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. We found that the service was complying with the conditions applied to the authorisations.

We asked staff if they had undertaken training in MCA/DoLS. Comments included, "Yes, I've done training in these, though the nurses take the lead," and "Yes, this stands for deprivation of liberty. Nurses take the lead with this," and "Yes, I know what they are."

Staff were aware of how to seek consent from people before providing care or support and told us they would always ask before providing care. People living at the home told us staff always sought their consent before delivering care to them. People's care files contained signed documentation giving consent to care and treatment, the sharing of information, use of a photograph, and where applicable the use of a wheelchair lap-belt and a flu vaccination. One staff member said, "Always ask people first and use their name. You can ask but they may not always answer. If people refuse, they refuse; all you can do is go back and ask again."

We observed staff knocking on people's door and waiting for a reply before entering. We also observed staff asking people for their permission before doing anything. For example, in the morning one staff member entered a person's room and said, "Good morning, are you ready for your breakfast yet; would you like me to go and get it for you." We observed breakfast being taken into another person's room; the staff member explained what was for lunch and supported the person to eat it. The staff member asked the person if they wanted the food before giving each mouthful and if they were ready for the next one. The staff member was engaged in conversation with the person throughout, which meant that the experience was more than just task orientated.

The people we spoke with told us the food provided at the home was of a good quality. One person said, "It's lovely, you can have as much as you want and there is plenty choice." A second person told us, "Super, can't complain. There are normal breakfast options and a choice at lunch and evening meal." A third person commented, "Food is good and plenty of it."

We asked staff if they felt food and drink was readily available. Comments included, "Oh yes, always," and "Yes, people can ask when they want anything," and "People can have whatever they want, we have a set menu but they can have something different provided we have got it."

People had nutritional care plans in place and care plans also contained records of visits by other health professionals. We saw that a range of professionals including GPs, speech and language therapists (SALTs)

and district nurses had been involved in people's care. We saw people's weights were being monitored on a regular basis where a need for this had been identified.

When we arrived at the home we observed the breakfast meal. Breakfast was porridge, cereal, toast, jam or marmalade and a warm or cold drink. There was also a choice of a hot breakfast on request. The service had achieved a food hygiene rating score (FHRS) of five. Fridges and freezers were well-stocked in addition to a plentiful supply of dry food goods. The menu was displayed both inside and outside of the dining room. People who used the service could choose an alternative meal option on any day if they wished. Vegetarian options and specialist diets were also available.

Special diets were catered for, food allergies were recorded and people had nutrition and hydration care plans in place. Information on different diet types, such as a soft diet or thickened fluids had been sought from the speech and language therapy team (SALT) and this informed the kitchen staff how to prepare and serve these types of foods. Details of peoples' specialist diets were available in the kitchen along with information on individual likes and dislikes. Each person had a preferred food items and drinks list.

Food temperatures were recorded at each meal before serving. We observed staff taking breakfast to people who wished to stay in their room on nicely presented trays that helped to make the food look inviting to eat. We saw that the food on these trays was covered with a protective plastic lid that helped retain heat and protect the food as it was being taken to rooms.

We spoke with the chef about food and nutrition and they told us, "When anyone is due to be admitted, I get a dietary sheet which provides any information around their meals, assistance they need, special diets, thickened drinks and so on. We currently have people who are diabetic, some who have pureed diets and some who we just have to puree their meat as they are okay with the rest. We have a three weekly menu in place. A request sheet for choices goes out each day for the day after. Breakfast is always the same, cereals, toast, full English, though if someone just wants egg on toast we can provide this. For lunch we have a choice of starter, choice of main course and a desert, for evening meal we have a choice of sandwiches and either a pudding or homemade cake. We review the menu to see if people are enjoying it, and if not liking something we will change it."

At the last inspection we found the environment was not consistently effective for people living with dementia. At this inspection we found that improvements had been made to the environment to assist people to orientate around the building. There were pictorial signs on bathroom/toilet doors, the dining room and lounges. People's bedroom doors had their picture on, along with other photographs or items that had meaning to them. Some bedrooms had a 'memory box' on the wall outside their room that contained familiar items, which would assist some people to recognise their bedroom. There were assisted bathrooms with equipment to aid people with mobility problems, and some toilets had different coloured seats. The home had been redecorated and was bright and airy throughout and different areas had been painted with different colours to help people recognise where they were. There were pictures and murals throughout the home and some areas had been decorated with a musical theme.

Good

Is the service caring?

Our findings

We saw staff showed patience and encouragement when supporting people. We observed people were treated with kindness and dignity during the inspection. Care staff spoke with people in a respectful manner. For example at the lunch time meal we saw staff gently encouraging people to eat their food. On other occasions we saw staff carrying out one-to-one activities in people's bedrooms, such as nail painting and hand massage, whilst engaging in meaningful conversation with them such as talking about their past life history or the latest news items.

The people we spoke with told us staff were kind and caring. Comments included, "Oh yes, they are lovely," and "Yes, they are very helpful," and "Yes, very much so." A visiting relative said, "I want to tell you how wonderful this place is. The staff and management are all very caring and can't do enough for you. I am really happy with the service." Other comments from relatives included, "Yes, definitely so, and "Yes, they are all lovely."

People's bedroom doors had a sign on that read 'Observe people's dignity, knock before entering' and we saw that the care staff followed this. We saw that people living at the home were well groomed and nicely presented. People said they felt treated with dignity, respect and were given privacy at times they needed it. One person said, "Oh yes, they are good with this." Another person told us, "Oh yes, they always ask me before doing anything." A third person said, "Oh yes, they always knock on my door and wait for an answer."

Relatives we spoke with were also complimentary about how staff respected people's dignity. Comments included, "Yes, constantly," and "Yes, they do," and "Yes, there are no problems with this," and "Yes, they are marvellous." Staff were also able to describe to us how they aimed to treat people with dignity and respect. Comments included, "Be respectful, cover up and close doors. I treat people how I would like to be treated," and "I always close doors and curtains when assisting someone," and "I cover people up, knock on their door, and leave them to use the toilet independently if it is safe to do so," and "I make sure doors are shut and I cover people up."

We observed people who used the service being hoisted at different times during the day and saw staff practice was appropriate and safe. Staff maintained continuous eye contact and were talking to people who were being hoisted throughout the process which demonstrated people were treated with care and consideration. We saw that the two care staff completing the moving and handling manoeuvre were confident in what they were doing.

Throughout the course of the inspection we heard lots of chatter and laughter between staff and people and there was a positive atmosphere within the home. Staff interacted with people throughout the day and it was clear that they had a good understanding of the individual people who used the service. We observed many occasions where staff spoke privately on a one-to-one basis with people.

During our inspection we looked to see how the service promoted equality, recognised diversity, and protected people's human rights. We found the service aimed to embed equality and human rights though

good person-centred care planning. Support planning documentation used by the service enabled staff to capture information to ensure people from different groups received the help and support they needed to lead fulfilling lives, which met their individual needs.

People said staff tried to promote their independence when delivering care and allow them to try and still do things for themselves. One person said, "Oh yes they do. I try to do as much for myself as I can and the staff let me." We asked relatives if they thought staff promoted people's independence and comments received included, ""Yes, they do this very well," and "Yes, as much as they can," and "Yes, they do."

People who used the service and their relatives told us that staff listened to them and were approachable. Comments from relatives included, "The owner is brilliant, very approachable and willing to listen," and "The nurses in the office are brilliant. If I said [my relative] was breathing a bit shallow, there would be someone straight up," and "If we have any issues, we sit together with the staff and talk about it." A person who used the service said, "Yes, all the time, no complaints there." Another person told us, "Yes, they're always there to give advice."

People's care files contained end of life care plans, which documented people's wishes at this stage of life where they had been open to discussing this. Staff told us they involved families when developing care plans or carrying out assessments. The people we spoke with living at the home and a visitor to the service confirmed this was the case. At the time of the inspection no person was in receipt of end of life care and each care file had a section about advanced decisions. Where people had made an advanced decision regarding end of life care this was recorded correctly, dated and signed appropriately.

At the last inspection whilst reviewing the care plans of people who used the service we found that a number of Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) forms that were written by the person's GP were not accurately completed and had key information missing. At this inspection we found that these records had been reviewed and were now completed correctly, including information regarding who had been consulted and evidence as to how a DNACPR decision had been reached.

Good

Is the service responsive?

Our findings

People living at the home told us they received a service that was responsive to their needs and relatives told us they were involved in care planning and reviews. Comments received included, "Yes we are, although my sister usually does this," and "Yes we are. A dementia specialist comes out to see [my relative] every month. If we can't make it, the staff will feedback to us what has been discussed," and "Yes, we are involved in these," and "I know what's going on, I've no complaints."

Care plans contained a good level of detail and had a person centred approach. We saw that people who used the service had been involved in developing their care plan and this was recorded in their care plan information. There were entries in people's records which identified that the person had been involved and discussions had been held with them, and where applicable, their relative. One person said, "They do talk to me about what I would like to do." Two other people we spoke with could not remember if they had been involved in planning their care; we checked their care files and saw that they had been involved and this had been recorded.

We spoke with a visiting healthcare professional who told us, "This is one of the better homes I visit and people are well looked after. Staff use their knowledge and skills effectively to respond to people's changing needs. They refer into my service appropriately, skin care is managed well and referrals are timely. People's relatives are also well looked after. If I had to choose a home for my own parents it would be here."

We saw the home had been responsive in referring people to other services when there were concerns about their health. For example, people with swallowing difficulties had been referred to Speech and Language Therapy team (SALT) and provided with an appropriate diet type following their assessment.

When people first started living at Rivington View, an initial assessment was undertaken. This enabled staff to establish what people's care needs were and the type of individual care people required. A discharge plan/checklist was also completed when people came to the home for hospital. We saw these provided a focus on input from other professionals, an update on any on-going treatment and appointments, medication details, clinical and nursing care information, any equipment required and details of any on-going additional services.

At the last inspection we found that the care people received did not consistently meet their needs and reflect their preferences and this was a breach of Regulation 9 (1) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.During the inspection we found that the format of the care plans had been amended and they were more person-centred and the provider was now meeting the requirements of this regulation.

We looked at five care plans for people living at the home. The care plans provided an overview of people's care needs following their initial assessment and any actions staff needed to complete and follow in order to meet their needs. We saw people had a wide range of care plans in place, taking into account areas such as maintaining a safe environment, moving and handling, privacy/dignity, personal care, nutrition/hydration,

continence, night time routines, communication, swallowing difficulties and constipation. Each section of the care plans we looked at had been reviewed each month, or if/when there was a change to people's care needs. Care plans were also audited each month by the manager to ensure consistency and quality of recording.

Each care plan that we looked at contained a document called 'This is me' with photo of the person using the service. 'This is me' was developed by the Alzheimer's Society as a simple and practical tool that people living with a dementia can use to tell staff about their needs, preferences, likes, dislikes and interests. In each of the five care plans examined this had been reviewed each month.

People told us that nurses reviewed their care plans and involved other professionals as necessary. One person said, "The nurse reviews my care plan. The social worker also comes in and the physiotherapist also has input." During the course of the inspection a minister visited the home to provide spiritual support to a person. They told us, "I've come to see [person] because they wanted to see me before Christmas." This demonstrated that the service responded appropriately to individual requests regarding spirituality.

Care plans captured details such as family background, education, spouse/partner details, children, employment, interests, travel and religion and was an overview of each person's life history. This meant staff had access to sufficient information about how to provide care to people based on their likes, dislikes, preferences and previous experiences. A staff member told us, "Person centred care is about the care of the individual person, so that we make sure we meet every day needs." A second staff member said, "It's about the specific person and what they want."

We saw that there were a variety of 'thank you' cards displayed in the home from relatives of people who had used the service. Comments included, 'Thank you so much for caring for [my relative]. Those last weeks were so important to me and the family,' and 'Thank you to [staff name] and all your fabulous staff for all the care and attention you gave to our Dad,' and 'I would like to thank you all for caring for [my relative] so well during his last year. The more I see of the work involved and the demands placed on staff the more I appreciate the work you do often under difficult circumstances. I know it was not always easy to look after Dad with his limited mobility and lack of communication but you managed to do this. I am exceptionally grateful that he was able to be nursed until the end in your home, it was peaceful and dignified.'

Visitors were encouraged to provide feedback to the home through questionnaires. There was also a 'suggestions box' in the entrance hallway where people could post comments. We looked at feedback recently received and saw that the service responded to people's comments. For example one relative had suggested the need for visitor's chairs and we saw that these had been provided and were in the lounge area. Other feedback received included, 'It has always been a home from home, thank you for all your hard work and consideration at all times,' and 'I cannot rate the home and staff highly enough. I know that my brother is safe and well looked after and all needs are met efficiently and effectively.'

People were able to personalise their own rooms. All rooms inspected had personal family photographs and items relevant to the individual and people could use their own bedding if requested.

There was a system in place to handle and respond to complaints and we saw the home had an appropriate policy and procedure in place, which was up to date and informed people of the steps they could take if they were unhappy with the service they received. There was also information displayed around the building for people to read. The people we spoke with said they had never felt the need to complain, but would feel comfortable speaking with staff and raising concerns. One person said, "I would go to the lead nurse if I had a complaint. Another person told us, "I can talk to any of the nurses or staff if I was worried."

We also spoke with people's relatives regarding the complaints process. One relative said, "I've never had any. It's worked out so well for [my relative] coming here." A second relative told us, Yes I know what to do but I've never needed to complain about anything." A third relative commented, "If I had any complaints I would speak to someone in the front office."

We looked at the activities available at the home and also how people were stimulated throughout the day. The home employed an activities co-ordinator who told us they split their time between group based activities such as bingo, music/singing, card/board games and 'one to one' activities for people who were cared for or chose to stay in bed during the day, which could include hand manicures/massages.

During the course of the inspection we observed occasions when staff were supporting people in their own rooms to have their nails painted. We observed that staff interacted well with the person being supported, holding conversations that were meaningful to them and taking their time. A staff member told us, "For people who stay in their rooms, the activities coordinator will read with them, do reminiscence activities, do pamper sessions and their nails." Another staff member told us, "We've had carol singers in recently and there's quite a lot going on Monday to Friday."

We asked people about their views on activities and if there was enough going on to stimulate them throughout the day. One person said, "Yes, you can play bingo, dominoes, make cards. There is a quiet room upstairs for reading, I am happy with what is available." Another person told us, "I don't know what activities they have here to be honest. I choose what I do with my time." A relative commented, "Quite often in afternoon [my relative] goes up to the quiet room to do activities, play dominoes, do art & craft." A second relative told us, "There's a lot done upstairs; however [my relative] doesn't like getting involved and prefers to be on their own." A third relative said, "People don't go out of the home on outings, even though they advertise that this happens."

There was a notice board in the activities room, which identified different activities. Recent activities had included Christmas decoration making, flower arranging, reminiscence, chatterbox, books, games and flash cards. A hairdresser regularly visited Rivington View. The hairdressing service was provided in a first floor bathroom that had an adapted 'salon style' sink for washing hair which contributed to a positive experience for people.

During the course of the inspection, we observed activities taking place in the activities room. Some people had been drawing and there was a group dominoes activity taking place, with games and craft activities in the afternoon. The activity room had a range of different equipment such as knitting/sewing materials, boxed games, painting/drawing equipment, balls, puzzles and quiz items. A visiting healthcare professional said, "I regularly see people out of bed and in different places in the home so there is regular movement that helps to avoid isolation. Staff take on board people's wishes and my advice and always know why I am here."

Each person had an activities list that identified what activity they had taken part in, which staff attended, an evaluation of the usefulness of the activity, for example one evaluation stated, 'The picture cards brought back lots of memories which got people talking about their lives.'

At the last inspection we were concerned that people were left alone in the lounge unsupervised for long periods of time. At this inspection we found that staff were vigilant with people in the lounge area and no-one was left alone for any length of time. Staff came in and out of the lounge, and held short conversations with people, checking they were well, asking if they needed any assistance or bringing them drinks.

Requires Improvement

Is the service well-led?

Our findings

There was no registered manager in post. 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.

Since the date of the last inspection the registered manager had taken up a different post within the home and another person had been recruited as registered manager in May 2016 but had not fully completed the process of registering with CQC and due to a change in circumstances they were unable to continue in the role and left the home in August 2016. We spoke with the provider about this issue and they told us it had been difficult attracting candidates for the role in the past and they intended to review the job package on offer with a view to making it more attractive to potential candidates. A visiting healthcare professional said, "In my opinion the home works perfectly well without a manager. The service seems to be very well organised and I have no concerns about this establishment."

We found the nurses were very approachable and engaging and facilitated our requests throughout the inspection, as did the rest of the staff team. They told us they operated an 'open door policy' meaning people could discuss concerns with the manager at any point and these would be taken seriously. Staff told us there was a good atmosphere within the home. One staff member said, "The atmosphere is good and the home is run really well, and I've no issue with this. A second staff member said, "This is a well-led home and I'm happy with everything."

People who used the service were aware of who was in charge, one person told us, "The nurses are running the unit at the moment." A second person said, "We go to [nurse name] if we need anything." Staff told us they enjoyed working at the home and they attended team meetings. One staff member said, "Yes we have meetings but they're not held constantly." Another staff member told us, "If a meeting happens a notice is put up in the staff room, the last one was about six to eight weeks ago."

Relatives of people who used the service also told us they felt the home was well-led. One person said, "The nurses run the home [nurse name] and [nurse name] are brilliant." Another relative told us, "The nurses are all good and do a good job." A third person commented, "The owner is also here a lot." We found that relatives meetings were not held regularly. One relative said, "We haven't had any of these but I'm sure I could meet with someone if I wanted to. Overall we are very happy with everything here." Another relative told us, "I can only recommend this place. If I had to go into a home I would definitely want it to be here."

We looked at the systems in place to monitor the quality of service. The service undertook regular audits covering areas such as medicines, care plans, nursing notes, the kitchen, people's rooms, activities, complaints, the overall premises and fire safety. Additionally each section of people's care files were also audited each month to ensure they were up to date and captured relevant information. An action plan was then created from each audit.

We looked at accident and incident records and saw that these were recorded and audited on a monthly basis. For those people who had sustained a fall, there was a quality assurance audit completed on a monthly basis by the nurses.

We found that regular service audits were being carried out. We tracked two audits and found that the process had been followed correctly and the manager had signed-off actions from the previous audits as complete. We looked at environmental audits and checks and found that these were carried out each month. These considered individual rooms, communal areas such as lounges, toilets and dining rooms, the garden area, storage areas, movable facilities such as wheelchairs and appliances, fixed facilities such as stair rails and laundry areas.

A quality assurance file was in place and contained records of audits that had been carried out. We saw that the supplying pharmacist had also carried out a 'pharmacist advice visit' in July 2016 to provide guidance regarding the management of medicines, which we saw were managed safely.

Information was also supplied each month to the CCG using the NHS Safety Thermometer. The NHS Safety Thermometer provides a 'temperature check' on harm that can be used alongside other measures of harm to measure local and system progress in providing a care environment free of harm. This allows services to measure harm and the proportion of people that are 'harm free' during their working day, for example at shift handover. These systems meant that the service could identify and potential shortfalls at the home and take appropriate action to ensure people received an improved quality of service.

Staff had access to a wide range of policies and procedures. These included medication, nutrition, moving and handling, safeguarding, health and safety and infection control. These could be viewed by staff if they ever needed to seek advice or guidance in a particular area.

Staff understood their role in sending notifications to CQC and had sent us notifications as required by the regulations. People's care records were kept securely and confidentially, and in accordance with legislative requirements

The service worked alongside other professionals and agencies in order to meet people's care requirements where required. Involvement with these services was recorded in care plans and included opticians, social workers, chiropodists, SALT, doctors and NHS health care workers.

There was a service user guide and statement of purpose in place. A statement of purpose is a document which includes a standard required set of information about a service. When people were given a copy of the service user guide they were also given a copy of the complaints policy, a satisfaction questionnaire and terms of residence.

The service had a business continuity plan that was recently reviewed in March 2016. This included details of the actions to be taken in the event of an unexpected event such as the loss of utilities supplies, fire, loss of IT, an infectious outbreak or flood. This meant that in the event of an unforeseen disruption to the service there were robust plans in place to provide continuity of support people using the service in a safe and coordinated manner.

There was an up to date certificate of registration with CQC and insurance certificates on display as required.