Innocare Limited

Riverslie

Inspection report

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Date of inspection visit: 12 and 13 February 2015
Date of publication: 21/04/2015

Ratings

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

Overall summary

Riverslie provides residential and nursing care for up to 26 people. Accommodation is provided over three floors, with a dining room, lounge and bedrooms on the ground floor. A passenger lift and ramps allow access to all parts of the home and the large enclosed garden.

This was an unannounced inspection which took place over two days on 12 and 13 February 2015. The inspection team consisted of an adult social care inspector.

The service did not have a 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. We told the acting manager to ensure an application for registration was received by CQC.

When we spoke with people living at Riverslie they told us they were settled and felt safe at the home. We were told: "It's a lovely place. Staff are there when you need them." "I don't feel anything could happen here. There's always staff around." Visitors we spoke with commented: "It's very good – my relative has done well here and feels at home" and "There is always staff available when we visit and they seem very attentive. It seems a safe environment." We saw from the duty rota that the staff ratio was consistent to provide necessary safe care.

Summary of findings

We looked at how staff were recruited. We looked at staff files and asked the manager for copies of appropriate applications, references and necessary checks that had been carried out to ensure staff employed were 'fit' to work with vulnerable people. The manager could not provide evidence of the required checks necessary.

You can see what action we told the provider to take at the back of the full version of this report.

We spoke with a visiting family member who said they found the service to be good at managing any risks, so that their relative was as independent as possible. When we reviewed the care of some of the people living at the home we found that risks to people's health such as monitoring of falls and risk of pressure sores were assessed and monitored.

We looked at how medicines were managed. We saw that medicines had been given and people told us their medicines were given on time. We found some anomalies with the medication administration records, however, which meant that they were not always clear. This meant there was a potential risk that some medicines may be missed or given in error. We found that overall people were still not fully protected against the risks associated with medicines because the provider's arrangements to manage medicines were not consistently followed.

We also found that people had not been assessed and given the opportunity to manage all, or aspects of their medicines which would encourage their independence.

You can see what action we told the provider to take at the back of the full version of this report.

The staff we spoke with clearly described how they would recognise abuse and the action they would take to ensure actual or potential harm was reported. Training records confirmed staff had undertaken safeguarding training. All of the staff we spoke with were clear about the need to report through any concerns they had.

Arrangements were in place for checking the environment to ensure it was safe. For example, a health and safety 'walk about' was completed by the manager on a regular basis where obvious hazards were identified; we saw an example of this. Any repairs that were discovered were reported to the maintenance person and the area needing repair made as safe as possible.

We observed staff provide support to people and the interactions we saw showed how staff communicated and supported people as individuals. Staff were able to explain each person's care needs and how they communicated these needs.

We reviewed three people who had varying levels of medical and nursing needs. We saw that there had been regular input from various health care professionals and the home had made appropriate referrals when needed. People we spoke with told us that staff were quick to arrange for medical referrals if needed. One person told us, ''If anybody is ill [staff] check them all the time. [Staff] arranged for me to attend a [medical] appointment recently.''

We looked at the training and support in place for staff. Staff we spoke with said they felt the support by training provided and by the manager. Records we saw confirmed up to date training. Most staff had a qualification in care such as NVQ [National Vocational Qualification] or Diploma and this was confirmed by records we saw. This evidence a good knowledge base for staff to support them in carrying out their work.

We looked to see if the service was working within the legal framework of the Mental Capacity Act (2005) [MCA]. This is legislation to protect and empower people who may not be able to make their own decisions. People living at Riverslie varied in their capacity to make decisions regarding their care. We saw some good examples of people being assisted to make decisions regarding aspects of their care but this was inconsistent. Care being carried out with regard to the use of restrictive practice such as bedrails had not been adequately assessed in terms the person mental capacity and a 'best interest' decision. It was unclear who had been consulted as part of the decision. Similarly, there were decisions in place regarding the right to refuse specific medical treatment in case of a cardiac arrest ['do not resuscitate' (DNR) procedures]. Records and supporting care plans were unclear as to the decision making process.

You can see what action we told the provider to take at the back of the full version of this report.

We discussed with staff and the people living at the home how meals were organised. People told us the meals were good and well presented. We observed meals were

Summary of findings

served appropriately and the portion size was also appropriate. We saw that people who needed support to eat had sufficient staff time allocated and that staff took time to talk to and socialise with people.

People told us their privacy was maintained. One person commented, ''I spend most of my time in my room and this is respected.'' Another person said, ''Staff help when they need to but are not invasive.'' People told us they felt they were listened to and generally staff acted on their views and opinions. One person said; "They [staff] show concern and will always try and help.'' A relative we spoke with and people visiting at the time of the inspection were pleased with how staff displayed a caring attitude. We asked if there were any restrictions and were told relatives and visitors are free to visit at any time. One relative said, ''The reason I chose this home for my [relative] was that the staff approach is so good. They were open and friendly from the start.''

We asked people who lived at the home how staff involved them in planning their care. We were told that staff kept them up to date with any important changes and they felt reassured by this. We found, however, that people and/or their relatives were not routinely involved in reviews about the care or how care plans were drawn up. A relative said, ''Staff let me know what's going on but I haven't seen a care plan.''

You can see what action we told the provider to take at the back of the full version of this report.

We looked at the care record files for three people who lived at the home. We found that care plans and records did not contain evidence to show they were individualised to people's preferences and reflected their identified needs. Care plans lacked detail and some had not been updated, as the person care needs had changed. For example, one person had been reviewed in October 2014 by a health care professional and specific interventions prescribed and agreed to manage the person's care. The care plan had not been updated accordingly. The lack of accuracy, update and detail in peoples planned care might lead to an inconsistent delivery of care or care may be missed.

You can see what action we told the provider to take at the back of the full version of this report.

We looked at the daily social activities that people engaged in. We asked people how they spent their day. Mostly, people were happy with the daily level of activity in the home. Over both days we inspected there was an active program which included group and individual activities. These activities were appreciated by people living at Riverslie and helped provide a positive feeling of wellbeing for many.

We observed a complaints procedure was in place and most people, including a relative, we spoke with were aware of this procedure. We saw that any concerns or complaints made had been addressed and a response made.

We spoke with a member of the contracts monitoring team at social services who had visited the home in January 2015 as part of a safeguarding investigation. They told us the key issue had been the lack of detail in care records and the recommendation would be that these should be improved. On this inspection we found we had similar concerns about care records for people.

You can see what action we told the provider to take at the back of the full version of this report.

From the interviews and feedback we received, the manager was seen as open and receptive. One staff member said, ''We have had staff meetings and we can have our say and the manager will listen. You can speak to the manager any time.''

We enquired about other quality assurance systems in place to monitor performance and to drive continuous improvement. We found there was a lack of formal systems to gain feedback from people living at the home, and their relatives so the manager could not use people's views to develop the way the service was being run.

Other auditing and checking by the manager was also not evident. For example we accidents and incidents were not analysed to inform any overall patterns or lessons that may need to learnt for the home. The home's administrator showed us the system for managing people's personal allowances but these were not audited by the manager or provider.

On this inspection we found there were breaches of regulations covering, requirements relating to staff employed at the home, medication management, care and welfare including people's involvement in their care planning, maintenance of records and issues around

Summary of findings

consent to care and treatment. We were concerned that the home's current auditing and monitoring processes had not effectively identified any shortfalls or improvements needed.

We found that issues requiring the home to notify the Care Quality Commission had not been made. These included notifications about a serious injury to a person living in the home [person with a pressure ulcer], a person who had died and a safeguarding investigation.

You can see what action we told the provider to take at the back of the full version of this report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

There was a risk medicines were not administered safely. Medication administration records were not always clear. Medication audits had not identified these issues.

There was a good level of understanding regarding how safe care was managed. Care was organised so any risks were assessed and plans put in place to maximise people's independence whilst help ensure people's safety.

Staff understood what abuse meant and knew the correct procedure to follow if they thought someone was being abused.

There were enough staff on duty at all times to help ensure people were cared for in a safe manner.

There was a lack of evidence to show staff had been checked thoroughly when they were recruited to ensure they were suitable to work with vulnerable adults.

Is the service effective?

Requires Improvement

The service was not wholly effective.

We saw that the manager and staff were following the principals of the Mental Capacity Act (2005) and knew how to apply these if needed but evidence for this was inconsistent. There were examples where consent was not clear for some important aspects of care and treatment.

We saw people's dietary needs were managed with reference to individual preferences and choice.

Staff said they were supported through induction, appraisal and the home's training programme.

Is the service caring?

Good

The service was caring.

We made observations of the people living at the home and saw they were relaxed and settled. People we spoke with and a relative told us they were happy with the care and the support in the home and described the care and quality of life for people living at the home as of a good standard.

We observed positive interactions between people living at the home and staff. Staff treated people with privacy and dignity. They had a good understanding of people's needs and preferences.

People we spoke with and a relative told us the manager and staff communicated with them effectively about changes to care.

Summary of findings

Is the service responsive?

Requires Improvement 

The service was not always responsive.

People's care was not planned so it was personalised and reflected their current and on-going care needs. There was a lack of detail to personalise care plans and some were not updated. We found that the manager and staff team needed to include people in care planning and reviews.

A process for managing complaints was in place and people we spoke with and relatives were confident they could approach staff and make a complaint if they needed.

Is the service well-led?

Inadequate 

The service was not well led.

There is currently no registered manager for the service.

We found the current manager and staff to be open and caring and they spoke about people as individuals. There were a lack of systems in place to get feedback from people so that the service could be developed with respect to their needs and wishes.

On this inspection we found there were breaches of regulations covering standards in the home. We were concerned that the home's current auditing and monitoring of these had not effectively identified any shortfalls or improvements needed.

Issues requiring the home to notify the Care Quality Commission had not been made.

We found that records required for the running of the service had not been effectively maintained.

Riverslie

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 checked 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 was an unannounced inspection which took place over two days on 12 and 13 February 2015. The inspection team consisted of an adult social care inspector.

We were not able to access and reviewed the Provider Information Return (PIR) as the manager had not received a request for this before the inspection. The PIR 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 did review other information we held about the home.

During the visit we were able to speak with seven of the people who lived at the home. We spoke with two visitors to the home including a relative of a person living at Riverslie.

As part of the inspection we spoke with a social care professional who was able to provide feedback concerning recent reviews of care for people as well as a contract monitoring officer from social services.

We spoke with six staff members including care/support staff and the manager for the service. We looked at the care records for three of the people living at the home, four staff recruitment files and other records relevant to the quality monitoring of the service. These included medicines, safety audits and quality audits, including any feedback from people living at the home, professional visitors and relatives. We undertook general observations and looked round the home, including some people's bedrooms, bathrooms and the dining/lounge area.

Requires Improvement

Is the service safe?

Our findings

We looked at how staff were recruited and the processes to ensure staff were suitable to work with vulnerable people. We were shown the homes recruitment policy which had last been reviewed in 2012. The policy said all new staff would be recruited, 'to comply with statutes, regulations and quality standards'. We looked at four staff files and asked the manager for copies of appropriate applications, references and necessary checks that had been carried out to ensure staff employed were 'fit' to work with vulnerable people. The staff files we saw were disorganised and lacked important information. For example, three of the files had no record of a Disclosure and Barring Service [DBS] check. This checks an applicant's police record and is an important to help ensure staff suitability. The manager was not able to produce any evidence that these checks had been made for the three staff. Following the inspection we were advised by the manager that checks had been made and the administrator had the appropriate reference numbers secured on a computer. Evidence of this was sent after the inspection visit.

We looked for evidence that appropriate references had been asked for and received. For two of the staff we could not find adequate references. One staff file contained only one reference which was addressed to the applicant and had been brought along by the applicant. There was no evidence on file that a reference had been requested by Riverslie. Another file contained one reference only – the second had been requested but had not arrived. The manager confirmed that two written references were needed. The home's policy did not specify written references.

This is a breach of Regulation 21(b) of the HSCA 2008 (Regulated Activities) Regulations

2010.

We spoke with a visiting family member who said they found the service to be safe and very good at managing any risks, so their relative could be as independent as possible. The relative told us, "Care has been organised so that my relative has staff when needed.'' This meant the person felt safe and comfortable in the home. When we reviewed the care of some of the people living at the home we found that risks to people's health such as, monitoring of falls and risk of pressure sores were assessed and monitored.

Another person had periods where they were confused and were at risk of falling. We saw how the care plan supported the person so that risks could be minimised. Another person was restless at night and was at risk of falling from bed. Safety measures including the provision of bed rails had been assessed and put in place.

When asked about medicines, three people told us they felt staff were competent and they all said they got their medicines on time. One person told us, ''Medicines are kept in a locked cupboard in my room. The nurses give them out from here so there's no risk of an error.'' Medicine administration records [MARs] we saw were completed to show that people had received their medication. We saw part of the morning medication round and this was carried out safely so people got their medicines and they were recorded as per the home's policy; following each individual administration the records were completed by the staff. This helped reduce the risk of errors occurring. We saw that people's medicines were reviewed on a regular basis. Records confirmed this. We found external medicines such as creams were recorded by the staff administering the cream. We saw that people's medicines were reviewed on a regular basis. Care records we saw confirmed that some people had been reviewed recently by a visiting GP.

We found, however, some anomalies with the medication administration records [MARs] which meant that they were not always clear. This meant there was risk that some medicines may be missed or given in error. For example:

- Handwritten entries on the MAR charts that had not been signed by two staff to check accuracy. We discussed the 'best practice' of ensuring hand written medicine chart entries were signed by two staff as this helped ensure entries had been copied correctly.
- We asked about one person who we were told was on PRN [give when needed] medication [for pain relief]. Staff could find no entry in any of the care plans regarding this medicine and in what circumstances it was to be administered. The importance of a PRN care plan is that it supports consistent administration and on-going review.

Requires Improvement

Is the service safe?

- We reviewed one person who had been prescribed medication to help with bowel management. This was administered twice daily by invasive procedure. Staff could not locate any supporting care plan for this. The importance of a care plan is to explain the reasons and background to the person's condition and to include information for staff regarding other supportive interventions such as, diet and fluid intake to help manage and monitor the person's condition. The care plan would also help ensure on-going reviews/ evaluations are carried out.
- We looked at the medication audit which the manager had carried out on 9 January 2015. This was rather generalised and had not identified issues that we had noted. For example, there was a tick next to a box which read 'PRN care plans in place' yet we found examples where this was not the case. It did not include detail such as, which records were reviewed. We discussed the need to review the audit tool to make it more fit for purpose. We referenced the NICE guidance; 'Managing medicines in care homes' as a useful source for further developments.

We discussed these anomalies with the manager and staff. We did not find any evidence that people had not received their medicines. The medication administration records did not always support a thoroughly safe practice however.

These findings were a breach of Regulation 13(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

There were no people self-medicating in the home. We spoke with two people who told us they had never been asked about the possibility of self-medicating and presumed medication administration was role staff carried out. We spoke with staff who confirmed this to be the case. We discussed with the manager the need to review the home's policy so people were given the opportunity to manage all, or aspects, of their medicines as this would encourage their independence in this area.

These findings were a breach of Regulation 17(1)(b)(2)(e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The staff we spoke with clearly described how they would recognise abuse and the action they would take to ensure actual or potential harm was reported. Training records confirmed staff had undertaken safeguarding training. All of the staff we spoke with were clear about the need to report through any concerns they had.

When we spoke with people living at Riverslie they told us they were settled and felt safe at the home. People commented that the home was settled and standards of care were consistent.

We were told: "It's a lovely place. Staff are there when you need them'', "I don't feel anything could happen here. There's always staff around", "They look after you." Visitors we spoke with commented: "It's very good – my relative has done well here and feels at home'' and ''There is always staff available when we visit and they seem very attentive. It seems a safe environment.''

We asked about staffing at the home. To support the 24 people living at Riverslie there was normally a minimum of four care staff and a nurse on duty. The manager was often in addition to these numbers [as on the second day of the inspection].We saw from the duty rota that this staff ratio was consistently in place to provide necessary safe care. Nursing and care staff were supported by ancillary staff such as a cook, domestic staff, laundry staff and administrative staff.

We asked people living at the home if there were enough staff on duty. We were told; "There are enough staff to look after me. I don't have to wait long for anything." We spent time in the lounges over two days and saw that staff were available for people when they needed support.

There had been a safeguarding investigation involving the care of three people at the home since the last inspection. This involved appropriate care around basic observations and monitoring of people's health. The home had assisted the local authority safeguarding team and agreed protocols had been followed in terms of investigating and ensuring any lessons had been learnt and effective action had been taken. This approach helped ensure people were kept safe and their rights upheld. We saw that the local contact numbers for the Local Authority safeguarding team were available.

Arrangements were in place for checking the environment to ensure it was safe. For example, a health and safety 'walk about' was completed by the manager on a regular basis where obvious hazards were identified; we saw an example of this. Any repairs that were discovered were reported to

Requires Improvement

Is the service safe?

the maintenance person and the area needing repair made as safe as possible. We saw some documented evidence that regular safety checks were made including nursing equipment and fire safety. Two people had been assessed as safe to smoke in their rooms. We saw risk assessments in care files to support this. We saw that personal evacuation plans [PEEP's] for the people living in the home was available in the staff office but these was out of date and did not include all of the people in the home. This was updated while we were on the inspection.

Requires Improvement

Is the service effective?

Our findings

We looked to see if the service was working within the legal framework of the Mental Capacity Act (2005) [MCA]. This is legislation to protect and empower people who may not be able to make their own decisions. People living at Riverslie varied in their capacity to make decisions regarding their care. Where people had lacked capacity to make decisions we saw that decisions had been made in their 'best interest' although the evidence for this varied. For example, one person had medicines administered covertly [this is medicine given to a person without their awareness, who lacks capacity to decide for themselves, but the treatment is needed in their best interest]. We saw this had been managed well in relation to good practice and within the MCA Code of practice with a supporting care plan and evidence of appropriate input from professionals and people involved in supporting the person.

Other examples were not as clear. Two people had bedrails in place as a safety measure. There was a 'risk assessment' in place but this did not record any consent. Consent here is important as the use of bedrails can be seen as a restriction and needs regular review. We were told the people 'lacked capacity' to give consent and the decision had been made in the person's best interest. There had been no assessment of the person's mental capacity recorded for this particular decision however. It was also unclear who had been consulted as part of the decision; a relative for example.

Two people had decisions in place regarding the right to refuse specific medical treatment in case of a cardiac arrest ['do not resuscitate' (DNR) procedures]. One DNR record lacked clarity around the person's mental capacity [no evidence of this being tested], who had been consulted in the person's best interest and whether this was to be further reviewed. There was no supporting care plan to clarify these issues. We discussed how DNR decisions could be better evidenced and recorded. The manager said they would address this.

We asked whether people had given consent for staff to manage their medicines. We were shown three 'generic' consent forms which included a list of nursing and care procedures, including medication administration, with signatures on. This was not dated and it was not clear whose signature it was. We discussed how consent for medications might be better evidenced.

These findings were a breach of Regulation 18(1) & (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The manager was able to talk about aspects of the workings of the MCA and discuss other examples of its use. We were told, at the time of our inspection, the home did not support anybody who was on a deprivation of liberty authorisation [DoLS]. DoLS is part of the Mental Capacity Act (2005) and aims to ensure people in care homes and hospitals are looked after in a way that does not inappropriately restrict their freedom unless it is in their best interests. We found the manager knowledgeable regarding the process involved if a referral was needed.

We observed staff provide support and the interactions we saw showed how staff communicated and supported people as individuals. Staff were able to explain each person's care needs and how they communicated these needs.

We looked in detail at the care received by some of the people living at the home. We spoke with the people concerned and a relative, as well as checking information in care files. We reviewed three people who had varying levels of medical and nursing needs. We saw that there had been regular input from various health care professionals and the home had made appropriate referrals when needed. For example, one person had a medical condition requiring regular monitoring and follow up. We saw that these had been followed through. All of the people we reviewed had a record in their care notes recording professional support and these evidenced regular reviews by GP's, mental health specialists, physiotherapy and dieticians as needed. People we spoke with told us that staff were quick to arrange for medical referrals if needed. One person told us, ''If anybody is ill [staff] check them all the time. [Staff] arranged for me to attend a [medical] appointment recently.''

People we spoke with, relatives and health care professionals were aware that staff had the skills and approach needed to ensure people were receiving the right care. We saw a nurse speaking with a person who later told us, ''The nurse understands and takes time to listen. They sort things out for me.''

We looked at the training and support in place for staff. Staff we spoke with confirmed they had up to date and on-going training; they felt the support they got with

Is the service effective?

training was good. We were told the training was a good mixture of both in-house and external training. The manager supplied a copy of the staff training matrix which identified and plotted training for staff in 'statutory' subjects such as, health and safety, medication, safeguarding, infection control and fire awareness. This was up to date.

Staff told us that they had had appraisals by the manager and there were support systems in place such as, supervision sessions and staff meetings. One staff member told us that staff meetings were open and constructive. We saw the agenda and notes for a staff meeting dated 1 December 2014, which was well structured under various headings.

The manager told us that many staff had a qualification in care such as, NVQ [National Vocational Qualification] or Diploma. This was confirmed by records we saw where all but one care staff [nearly 100%] had a care qualification. This evidence a good knowledge base for staff to support them in carrying out their work.

We discussed with staff and the people living at the home how meals were organised. People told us the meals were good and well presented. One person said, ''It's very nice. If I didn't like it they would get me something else.'' Another person said, "I like the food, you get a choice for breakfast and tea. There's enough to eat.''

We observed the breakfast and dinner time meal and saw that meals were served appropriately and the portion size was also appropriate. We saw that people who needed support to eat had sufficient staff time allocated and that staff took time to talk to and socialise with people. People who required assistance with their meal were supported by staff. Nobody was rushed. The meal times were clearly seen as a social occasion. We saw the cook asking people for their preferences during the morning. The daily menu was displayed on a board at the entrance to the dining area.

Good

Is the service caring?

Our findings

We observed the interactions between staff and people living at the home. We saw there was a rapport and understanding. We asked people if they were treated with dignity, respect, kindness and compassion. We received positive comments: ''The staff are lovely. Couldn't ask for anything better'', ''The staff always take their time with you – nothing is too much trouble'', ''staff are smashing – they treat us very well.''

Everyone told us privacy was maintained. One person commented, ''I spend most of my time in my room and this is respected.'' Another person said, ''Staff help when they need to but are not invasive.'' People told us they felt they were listened to and generally staff acted on their views and opinions. One person said; "They show concern and will always try and help.''

Staff told us that they spent time talking with people living at the home and this was mostly in the afternoon as mornings could be very busy. We made some observations of both day areas over the two days of the inspection. We saw there was extra support form an 'activities organiser' and this was appreciated by a lot of people living at Riverslie. It meant that staff time was available in the morning and afternoon for increased social interaction. We saw staff taking time to interact and involve people throughout the day. The interactive skills displayed by the staff were positive and people's sense of wellbeing was very evident.

Throughout the inspection we observed staff supporting people who lived at the home in a timely, dignified and respectful way. Over the two days of the inspection we saw the home as busy for the majority of the time with lots of daily activity. We saw staff respond in a timely and flexible way, so people did not have to wait if they needed support. Staff were always on hand. We noted there was positive and on-going interaction between people and staff.

A relative we spoke with and people visiting at the time of the inspection were pleased with how staff displayed a caring attitude. We asked if there were any restrictions and were told relatives and visitors were free to visit at any time. One relative said, ''The reason I chose this home for my [relative] was that the staff approach is so good. They were open and friendly from the start.''

The staff we spoke with had a good knowledge of people's needs and spoke about the people they supported with warmth and understanding.

Requires Improvement

Is the service responsive?

Our findings

We asked people who lived at the home how staff involved them in planning their care. People who were able to give an opinion and relatives we spoke with varied in their opinions. We were told that staff kept them up to date with any important changes and they felt reassured by this. We found, however, that people and/or their relatives were not routinely involved in reviews about the care or how care plans were drawn up. A relative said, ''Staff let me know what's going on but I haven't seen a care plan.'' We saw that care plans had dates entered to say they had been reviewed by staff but these reviews had no detail recorded and there was no evidence that people or their relatives had been consulted or involved in any of the reviews.

These findings were a breach of Regulation 17(1) (b) (2) (b) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We looked at the care record files for three people who lived at the home. We found that care plans and records did not contain evidence to show they were individualised to people's preferences and reflected their identified needs. Some had not been updated in response to people's changing needs. For example one person's dietary needs had changed from the existing care plan some time previously but these had not been updated in the care plan. A date had been entered for a review of the care plan but no changes recorded. In another example we were told by staff that a person had been placed on a chart to monitor fluid intake. This was important to maintain their health but the person's care plan did not reference this care need. One person had been reviewed in October 2014 by a health care professional and specific interventions prescribed and agreed to manage the person's care. The care plan had not been updated accordingly. There was a dated evaluation in January 2015 which said the care plan 'doesn't need modifying'.

In other examples, we found a lack of detail to make plans personalised for the person concerned. One care plan for a person's personal care said, 'requires help with personal care' but no further detail for staff to follow regarding this person's preferences and individual choice of routine.

The importance of updated reviews of peoples changing care needs is that all staff and other people involved in the care of the person can have a contemporaneous reference point to help ensure a consistent approach to care. The lack of accuracy, update and detail in peoples planned care may lead to an inconsistent delivery of care or that care may be missed. We discussed this with the manager who acknowledged the findings and these would be addressed.

These findings were a breach of Regulation 9(1) (b) (i) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We looked at the daily social activities that people engaged in. We asked people how they spent their day. People varied in their responses. Some people preferred to spend time in their room. One person said, 'Staff used to help me to get out more but this doesn't seem to happen as much now.'' Mostly, however, people were happy with the level of activity in the home on a daily basis. These were generally organised by a designated staff member and activities provided a focal point and opportunity for socialisation. Ove both days we inspected there was an active program which included group and individual activities. On one day of our visit there was an external organisation visiting the home who also provided various activity based pastimes.

These activities were well appreciated by people living at Riverslie and helped provide a positive feeling of wellbeing for many. One person told us, '' I love getting involved and I help out with the activities as well.'' A relative said, ''There's always something going on. They do quizzes, flower arranging and arts and crafts.''

Staff told us that there was time to sit and socialise with people living at the home. One staff member had a pet dog who was a regular, daily, visitor. We saw the staff member introducing the dog and chatting and interacting with people living at the home.

We observed a complaints procedure was in place and most people, including a relative, we spoke with were aware of this procedure. The complaints procedure stated that the policy should be 'publically available in all areas of the home'. We found reference in the 'service user guide' in people's bedrooms and also in a folder in the entrance hall way. We discussed with the manager how a 'user friendly' and easily seen poster could be made available for people. We saw that any concerns or complaints made had been addressed and a response made.

Inadequate

Is the service well-led?

Our findings

The service did not have a registered manager in post. The Care Quality Commission [CQC] had no application to register a manager at the time of the inspection. The current manager had been in post since January 2014 when the last registered manager left the service. The current manager explained they had 'applied' to us [CQC] for registration in August 2014 and was told at that time to complete a management qualification before reapplying. We have no record of this. We asked the manager to send us some evidence of the application but this has not been forthcoming at the time of this report. We advised the manager to apply for registration.

We asked the manager about plans for further developments in the home. We were told that following the recent safeguarding investigations it became clear that the home records with respect to care planning and delivery needed to be improved. The manager was not aware whether a written development plan for the service had been developed by the provider.

We spoke with a member of the contracts monitoring team at social services who had visited the home in January 2015 as part of a safeguarding investigation. They told us the key issue had been the lack of detail in care records and the recommendation would be that these should be improved. On this inspection we found we had similar concerns about care records for people. We saw there was a lack of detail, update of care plans and lack of detail in reviews and evaluations of the care plans so it was difficult to follow how care was being delivered. We also found further examples where care records used in the management of the home were not clear. For example, the staff files did not contain the required checks for staff to work at the home. We also saw some of the policies used to run the home such as, the complaints policy, the 'service user guide' and recruitment policy. These had not been reviewed since 2012 by the last registered manager.

This is a breach of Regulation 20(1) (a) (b) i of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

From the interviews and feedback we received, the manager was seen as open and receptive. Staff told us they received going support; for example, staff we spoke with had had supervision or appraisal sessions and we were told there were regular staff meetings where staff could give their opinion regarding the running of the home. One staff member said, ''We have had staff meetings and we can have our say and the manager will listen. You can speak to the manager any time.''

We enquired about other quality assurance systems in place to monitor performance and to drive continuous improvement. We were told by the administrator and manager that a representative of the provider visits regularly. There was no record of the visits or what was discussed on the visits. The manager could not provide any records of any auditing or checking the provider carried out.

We asked about how people living at the home were able to feedback their opinions regarding the running of the home. The manager told us, ''Up till now we have not sent out any survey forms to get people's opinions.'' We asked about any other means of getting opinions. We were shown a copy of the notes from the last 'residents meeting'. This had been held in March 2014. The lack of formal systems to gain feedback meant that people living at the home, and their relatives, were not being canvased for their opinions and the manager could not use people's views to develop the way the service was being run.

The manager told us about weekly health and safety audits they had conducted on a weekly 'walk around' of the home. We saw an example of the last one conducted on 31 December 2014 but none since. When we checked the various safety certificates such as fire safety, legionella, gas and electrical safety, we found they were up to date. The home had responded to some recommended work by the fire safety authority from May 2014. This showed the service had responded to the findings from a statutory body.

Other auditing and checking by the manager was not evident however. For example, we were shown how accidents and incidents were recorded. The manager advised us these were not audited however. Currently the information regarding accidents were filed, but no assessment and analysis of these had been carried out to inform any overall patterns or lessons that may need to learnt for the home.

We looked at the way the home managed people's personal allowances. The homes administrator showed us the current system and we asked how these were audited

Inadequate

Is the service well-led?

by the manager or provider. We were told that the previous 'nominated person' representing the provider had left over a year ago. The new nominated individual had not carried out any audit of the monies since then.

On this inspection we found there were breaches of regulations covering, requirements relating to staff employed at the home, medication management, care and welfare including people's involvement in their care planning, maintenance of records and issues around consent to care and treatment. We were concerned that the home's current auditing and monitoring processes had not effectively identified any shortfalls or improvements needed.

We found on inspection that issues requiring the home to notify the Care Quality Commission had not been made. These included notifications about a serious injury to a person living in the home [person with a pressure ulcer], a person who had died and a safeguarding investigation. The manager said they would notify us retrospectively and would seek to review the regulations and guidance available regarding notifications.

These findings were a breach of Regulation 10(1) (b), 2(b) iii and (c) i of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services **How the regulation was not being met:** People did not always experience care, treatment and support that met their needs and protected their rights. Care plans lacked necessary detail and had not be updated to reflect changing care needs. Regulation 9(1) (b) (I)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services **How the regulation was not being met:** People were not being supported in promoting their independence with respect to managing their own medicines. People were not involved with developing their care plan and on-going care plan reviews. Regulation 17(1)(b) (2)(e)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment **How the regulations were not met:** Before people received any care or treatment they were not always asked for their consent. Where people did not have the capacity to consent, the provider did not fully act in accordance with legal requirements. Regulation 18(1) & (2)

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines **How the regulation was not being met:** People were not fully protected against the risks associated with medicines because the provider did not have appropriate arrangements in place to manage medicines. Regulation 13(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers **How the regulation was not being met** There was a lack of effective recruitment and selection processes in place. Regulation 21(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records **How the regulation was not met:** People's care records were not accurate and fit for purpose. Other records used for the running of the home were not fit for purpose. Regulation 20(1) (a) (b) i

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision

This section is primarily information for the provider

Action we have told the provider to take

How the regulation was not met:

The provider did not have an effective system to regularly assess and monitor the quality of service that people received.

The provider did not have a wholly effective system in place to assess and manage risks to the health, safety and welfare of people using the service.

Regulation 10(1) (b), 2(b) iii and (c) i

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.