Innocare Limited

Riverslie

Inspection report

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Ratings

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

Overall summary

We carried out an unannounced comprehensive inspection of this service on 12 & 13 February 2015 when seven breaches of legal requirements were found. The breaches of regulations were because we had some concerns about the way medicines were managed and administered within the home, the effective recruitment of staff, the planning and review of care needs, the need to gain consent to care and treatment, the accuracy and fitness for purpose of peoples care records and the effectiveness of management systems to regularly assess and monitor the quality and safety of service that people received.

We asked the provider to take action to address these concerns.

After the comprehensive inspection, the provider wrote to us to tell us what they would do to meet legal requirements in relation to the breaches. We undertook a focused inspection on 17 September 2015 to check that they had they now met legal requirements. This report only covers our findings in relation to these specific areas / breaches of regulations. They cover four of the domains we normally inspect; 'Safe', 'Effective', 'Responsive' and ' Well led'. The domain 'caring' was not assessed at this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for 'Riverslie' on our website at www.cqc.org.uk.

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.

Summary of findings

The service did not have a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission [CQC] to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The current acting manager has applied for registration and the application is being processed by CQC.

At our last inspection in February 2015 we found when 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 always act in accordance with legal requirements. We asked the provider to take action to address these concerns.

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. We looked at and reviewed the care of six people living at Riverslie. These people varied in their capacity to make decisions regarding their care. We found that there was a better understanding of good practice in this area of care but there needed to be ongoing consolidation of the improvements made. There still needed to more consistency of practice.

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

We found that action had been taken to improve the medication administration in the home. Medicines were administered safely. Medication administration records [MARs] were maintained in line with the home's policies and good practice guidance. We made recommendations to further develop the home's medication audit tool in line with best practice.

We found recruitment processes had improved and were much clearer. Staff had been checked when they were recruited to ensure they were suitable to work with vulnerable adults.

We found that action had been taken to improve the responsiveness of the home regarding the planning of the care. People's care was now planned so that it was more personalised and reflected their current and on-going care needs. Care records had been reviewed and were up to date. There was evidence that the manager and staff team had included people in care planning and this needed to be further consolidated.

We found action had been taken to improve the management and governance of the home. We found the provider was supporting the acting manager and had developed clearer and more effective systems to monitor standards in the home including getting information from people so that the service could be developed with respect to their needs and wishes.

We found that there were more comprehensive systems in place to identify, assess and manage risks to the health, safety and welfare of people living in the home.

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?
The service was safe.

We found that action had been taken to improve the safety of the home.

Medicines were administered safely. Medication administration records [MARs] were maintained in line with the home's policies and good practice guidance. We made recommendations to further develop the home's medication audit tool in line with best practice.

Staff had been checked when they were recruited to ensure they were suitable to work with vulnerable adults.

While improvements had been made we have not revised the rating for this key question. To improve the rating to 'Good' would require a longer term track record of consistent good practice. We will review our rating for 'safe' at the next comprehensive inspection.

Requires improvement

Is the service effective?
The service was not always effective.

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

Requires improvement

Is the service responsive?
The service was responsive

We found that action had been taken to improve the responsiveness of the home.

People's care was now planned so that it was more personalised and reflected their current and on-going care needs. Care records had been reviewed and were up to date. There was evidence that the manager and staff team had included people in care planning and this needed to be further consolidated.

Requires improvement

Is the service well-led?
The service was well-led.

We found action had been taken to improve the management and governance of the home.

The acting manager was applying for registration to the Care Quality Commission and this was being processed.

Requires improvement

Summary of findings

We found the provider was supporting the acting manager and had developed clearer and more effective systems to monitor standards in the home including getting information from people so that the service could be developed with respect to their needs and wishes.

We found that there were more comprehensive systems in place to identify, assess and manage risks to the health, safety and welfare of people living in the home.

We have noted the improvements made and have revised the rating for this key question to 'requires improvement' from 'inadequate'. To improve the rating to 'Good' would require a longer term track record of consistent good practice. We will review our rating for 'well-led' at the next comprehensive inspection.

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.

We undertook this focused inspection on 17 September 2015. The inspection was completed to check that improvements to meet legal requirements identified after our comprehensive inspection on 12 & 13 February 2015 had been made. We inspected the service against four of the five questions we ask about services; is the service safe? Is the service effective? Is the service responsive? Is the service well led? This is because the service was not meeting legal requirements in relation to these questions.

The inspection team consisted of an adult social care inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

During the visit we were able to speak with seven of the people who lived at the home. We spoke with two relatives of people living at Riverslie.

As part of the inspection we spoke with a health and social care professional who was able to provide some feedback concerning the home.

We spoke with three staff members including the nurse in charge at the time of the inspection. We looked at the care records for six of the people living at the home, two 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 and their relatives.

We undertook general observations and looked round the home, including some people's bedrooms, and the dining/ lounge area.

Requires improvement

Is the service safe?

Our findings

We carried out an unannounced comprehensive inspection of this service in February 2015 when breaches of legal requirements were found. The breaches of regulations were because we had some concerns about the way medicines were managed and administered within the home and the effective recruitment of staff. We asked the provider to take action to address these concerns.

At this inspection we looked at how staff were recruited and the processes to ensure staff were suitable to work with vulnerable people. We looked at two staff files and asked the administrator for copies of appropriate applications, references and necessary checks that had been carried out. We found that staff files had been audited and were now easy to access and contained a clear record of how staff had been recruited, inducted, and any training carried out and on-going supervision. We saw that required checks had been made so that staff employed were 'fit' to work with vulnerable people.

At our previous visit in February 2015 we had some concerns about the way medicines were managed and administered within the home. We asked the provider to take action to address these concerns. We spoke with the nurse in charge responsible for the safe management and administration of medicines in the home on the day of our inspection. We looked at Medication Administration Records (MARs) and care documents for four people who received staff support with their medicines. We found that improvements had been made and that medicines were being administered safely.

Medicines were stored safely and were locked away securely to ensure that they were not misused. Staff had signed the MARs to evidence medicines had been administered to people. The MARs were easy to follow and it was clear what medicines had been received and were being carried over from the previous month.

We asked about people who were on PRN [give when needed] medication, for example for pain relief. We found clear care plans had been draw up to include supportive information for these medicines. The importance of a PRN care plan is that it supports consistent administration and on-going review. This had been an improvement since the last inspection.

There was one person having medicines given 'covertly' [without their knowledge in their best interest]. We saw that the nurse in charge was aware of best practice issues around tis and these had been followed.

Care records we saw confirmed that some people had been reviewed recently by a visiting GP.

We reviewed one person who had been prescribed medication to help with bowel management. This was administered twice daily by invasive procedure. We saw there was a support plan for this for staff to reference. 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 also helped ensure on-going reviews/evaluations were carried out.

We did see a number of handwritten medicines for people on medication records. We saw that the staff member completing the record had not signed the entry. We discussed this and the nurse in charge did understand the need to ensure two staff checked and signed the record to reduce the risk of an error occurring.

We also saw that some people were prescribed external medicines such as creams. We were told by the nurse that these were generally administered by care staff. We asked for records to identify which staff had administered the creams but these records were not available. The nurse in charge had signed the medication record but had not administered the creams. We discussed the need to keep accurate administration records for staff who had administered medicines including creams.

We looked at a recent medication audit carried out by the manager. This had been further developed since the last inspection as the previous audit tool had been generalised and had been fit for purpose as it had not identified issues that we had noted on the inspection. The audit tool was now more detailed and covered more areas of medication administration and safety. We saw however that the two issues we had identified, handwritten entries and recording of creams, were not on the audit tool.

We recommend that further developments are made with reference to current best practice guidance issued regarding medication administration and safety.

Requires improvement

Is the service effective?

Our findings

We carried out an unannounced comprehensive inspection of this service in February 2015 when breaches of legal requirements were found. 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 always act in accordance with legal requirements. We asked the provider to take action to address these concerns.

At this inspection 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. We looked at and reviewed the care of six people living at Riverslie. These people varied in their capacity to make decisions regarding their care. We found that there was a better understanding of good practice in this area of care but there needed to be on-going consolidation of the improvements made. There still needed to be more consistency of good practice.

We saw some good examples where people had lacked capacity to make decisions and care had been planned in their 'best interest'. 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.

We saw evidence of people being asked about the delivery of their care and being asked to consent to this. For example some of the care plans were signed by people showing they had been discussed. In other care files we saw evidence of consent being discussed and sought for personal care, medication administration and other aspects of their care plan which had also been signed for. A form had been devised for this.

Other examples were not as clear. One person we reviewed had bedrails in place as a safety measure. There was a 'risk assessment' in place supported by a 'mental capacity assessment'. Consent here is important as the use of bedrails can be seen as a restriction and needs regular review. The use of the mental capacity assessment was an improvement from the previous inspection and the deputy manager understood the concept of using these assessments to measure people's capacity to make individual decisions in line with the MCA Code of Practice. In this example however it was clear that the person did not lack any capacity to make their own decisions and the assessment was not therefore necessary.

One person had a decision in place regarding the right to refuse specific medical treatment in case of a cardiac arrest ['do not resuscitate' (DNR) procedures]. The 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. This had been an issue on the previous inspection.

In another example we spoke with a person who had their cigarettes managed by staff as they had been identified as 'at risk'. The person told us this was 'OK' and staff had spoken with them about this, which evidenced good practice around consent. When we looked for formal assessment of the risk and recording of consent we could find no reference to this on the persons care file. The deputy manager said they were unsure how to formally assess and record this in line with the MCA Code of Practice. Following discussion the deputy manager drew up a care plan for this and gave the person concerned a copy to evidence consent.

The deputy manager told us that there had been some training by the operation manager around the MCA 2005 but that more was needed to underpin staff knowledge. The home did not have a copy of the MCA Code of Practice but one was down loaded from the internet during the inspection and the administrator told us they would order a copy. This would be a necessary reference for staff.

These findings were a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

Requires improvement

Is the service effective?

hospitals are looked after in a way that does not inappropriately restrict their freedom unless it is in their best interests. We found the deputy manager knowledgeable regarding the process involved if a referral was needed.

Requires improvement

Is the service responsive?

Our findings

We carried out an unannounced comprehensive inspection of this service in February 2015 when we were concerned that people's care plans lacked detail and had not been updated to reflect their changing care needs. The risk of not updating major changes to people's care plans is that staff may be unaware of their changed care needs and there is an increased risk that specific areas of care might not be effectively monitored and reviewed. We were also concerned that people were not being involved in the development of their care plans or any reviews. We asked the provider to take action to address these concerns. On this inspection we checked to make sure requirements had been met.

We found improvements had been made to meet necessary requirements. All of the care files we looked at had been re-written and updated to reflect peoples current care needs. These were organised and it was easy to find information. We saw they were being reviewed by nursing and care staff regularly. We saw evidence of people being involved in their care planning. For example we saw that in some instances people had signed their care plan and in others they had signed to say they had seen their care plan or it had been discussed with them. The evidence was not always as strong in all of the care files. The deputy manager told us that there was an intention to carry out full reviews of care plans with people living at the home and their relatives on a three monthly basis. This was also stated in the homes action plan. The deputy manager said this was still an aim and would be further consolidated in the future.

When we spoke with people they told us they felt involved in the planning of their care. Most did confirm that staff were regularly asking them how they felt or if they were okay, and all said they felt they could communicate their feelings or likes and dislikes to staff. Most residents could not recall or tell us the contents of their care plan but were able to say how the care being delivered met their immediate nursing or care needs. Some said that they had seen their care plan but had not been involved in on-going reviews.

Relatives spoken with were able to describe a higher degree of involvement, and particularly where they had in effect selected the home themselves. For example, there was evidence that relatives could be involved in some decision making. On relative said, ''We have spoken with the manager about Mum's best interests and we have made our views known. They have knowledge of this. We will speak to them again.''

Some of the people we spoke with had full capacity to plan their day and make their own decisions. They told us they were happy living at Riverslie but they very rarely involved themselves in any of the homes daily activities as these were based on the needs of people who had higher levels of care need. We were told that, in the past, there had been trips out locally but these did not now occur. There was little evidence of how the care was based on the previous individual life interests or hobbies of the people we met who often still had full or reasonable capacity. We fed this back to the deputy manager as an area that could be improved on.

We recommend that the service continue to develop and consolidate good practice around individualising the care and involving people in the daily life of the home.

Requires improvement

Is the service well-led?

Our findings

We carried out an unannounced comprehensive inspection of this service in February 2015 when we were concerned about the effectiveness of systems in place to identify, assess and manage the quality of service provision including risks relating the health, safety and welfare of people. We asked the provider to take action to address these concerns. On this inspection we checked to make sure requirements had been met.

We found improvements had been made to meet necessary requirements. This involved the way the home was run and the policies, procedures and overall governance [management] processes to help ensure consistent and improving standards.

At the time of the inspection the home did not have a registered manager. The home had not had a registered manager since January 2014 when the last registered manager left the service. The acting manager had recently applied for registration and this was being processed.

At the last inspection we found there was a lack of clearly identified leadership and lack of communication between the acting manager and the provider. The acting manager had lacked monitoring and support. The provider's action plan identified how they would liaise and support the acting manager more directly. The action plan stated, 'We have introduced an operations manager who will provide the manager with supervision and telephone support'. We were also told the operations manager would visit Riverslie every eight weeks and would help coordinate areas of the running of the home.

We saw evidence of this on the inspection. The acting manager was not present during the inspection but the deputy manager [who was also the nurse in charge on the day] told us the operations manager visited regularly and was providing on-going support for the home. For example they had carried out some training for staff. The deputy manager had also been employed to further clarify the management structure and to provide additional support for the manager. The role of the administrator had been reviewed to provide support in line with this. From the interviews and feedback we received, the manager was seen as open and receptive.

We looked at and reviewed some of the processes in the home that we had identified on the previous inspection to see if they had improved. We enquired about quality assurance systems in place to monitor performance and to drive continuous improvement. The deputy manager was able to show us a series of quality assurance processes and audits carried out internally by the manager. For example the medication audit had been revised and was more thorough. We saw 'care plan audits' had been devised and were being carried out to help ensure care records were meeting good practice standards. This had helped to ensure improvements had been made. The deputy manager told us all of the care plans had been rewritten. The care files we reviewed were more organised and it was easier to access information.

We were shown how accidents reported were analysed by the manager. We saw there was a monthly review by the manager for any accident or incidents reported. This was an improvement from our previous inspection. [We could not find any action points recorded by the manager and suggested these were also included].

We found management records were accessible and easy to find. We saw audits had been carried out on housekeeping, infection control, nursing equipment, bedrail safety and the kitchen. These internal audits were supported by some external monitoring and auditing by, for example, Liverpool Community Health [infection control] and the local council environmental health department. The improvements to the care records had been in liaison with the clinical liaison team at the local Clinical Commissioning Group [CCG] who were due to revisit and review improvements.

We saw that any recommendations made had been responded to by the home.

The action plan submitted by the provider told us that the service intended to include feedback systems into the home to collect people's views as to the running of the service which would then be used to plan any future changes. This included three monthly reviews of care plans with relative involvement, surveys to be sent to people using the service and their relatives, and meetings organised to get direct feedback from people.

The action plan told us that some of these still needed to be developed. We were shown notes of recent meetings held with people living at the home including relatives. Surveys and care reviews were still to be organised however.

Requires improvement

Is the service well-led?

At the previous inspection we were concerned that the home was not submitting statutory notifications informing us of significant events in the home. Since the last inspection we have received six notifications. The provider's action plan stated any notifications are discussed and monitored as part of the operation managers visits.

We have noted the improvements made and have revised the rating for this key question to 'requires improvement' from 'inadequate'. To improve the rating to 'Good' would require a longer term track record of consistent good practice. We will review our rating for 'well-led' at the next comprehensive inspection.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent **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.