Rivington View Limited

Rivington View Nursing Home

Inspection report

Albert Street,
Horwich,
Bolton,
BL6 7AW
Tel: 01204694325
Website: www.rivingtonview.com

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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 caring?	**Good**
Is the service responsive?	**Requires improvement**
Is the service well-led?	**Good**

Overall summary

We carried out an unannounced inspection of Rivington View Nursing Home on 24 June and 25 June 2015. We last inspected the service on 20 August 2014 when we found the service was meeting the standards in all outcome areas inspected.

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 29 people were using the service.

There was 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.

Summary of findings

People who used the service, their relatives and professionals we contacted told us they felt the service was safe. There were appropriate risk assessments in place with guidance on how to minimise the risks. Safeguarding policies were in place and staff had an understanding of the issues and procedures.

Medication policies were appropriate and comprehensive and medicines were administered, stored, ordered and disposed of safely.

We saw that people's nutrition and hydration needs were met appropriately and they were given choices with regard to food and drinks. Care plans included appropriate personal and health information and were up to date.

The environment was not consistently effective for people living with dementia and provided little stimulation. There was insufficient signage to aid people's orientation and help them to be as independent as possible.

During the inspection we looked at all areas of the home including people's bedrooms, the kitchen, bathrooms and communal areas such as the dining room and lounge. We observed the mid-day meal and spent time observing people in the lounge. We spoke with ten staff members, which included the registered manager, five carers, two qualified nurses, the chef and the domestic and a visiting NHS community health worker. We also looked at questionnaires completed by people who used the service and their relatives.

As not everyone at Rivington View was able to tell us about their experiences of living there, we used the Short Observational Framework for Inspection (SOFI.) SOFI is a way of observing care and support to help us understand the experience of people who could not talk to us.

The home worked within the legal requirements of the Mental Capacity Act (2005) (MCA) and Deprivation of Liberty Safeguards (DoLS).

People who used the service and their relatives told us the staff were caring and kind. We observed staff interacting with people who used the service in a kind and considerate manner, ensuring people's dignity and privacy were respected.

There was an appropriate complaints procedure and we saw that complaints were followed up appropriately.

A number of audits were carried out by the service, issues identified and actions put into place.

Medication policies were appropriate and medicines were administered, stored, ordered and disposed of safely.

We found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 with regards to staffing levels and person-centred care.

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 consistently safe

There was no formal system in place to determine staffing levels in relation to people's level of dependency of their care and support needs.

There were insufficient numbers of staff deployed in all areas of the building to meet the needs of the people using the service.

Staff had a good working knowledge about medication and conducted medication rounds in a safe and effective way maintaining necessary documentation.

Training records and competency assessments were in place for staff along with an induction process for new staff. The home had a system for error reporting and recording.

Is the service effective?

Requires improvement

The service was not consistently effective.

Care plans did not always reflect the current needs of people who used the service in respect of their nutritional requirements.

The service worked within the legal requirements of the MCA and DoLS and there was direction on how to assist someone in the decision making process.

The design of the environment was not always effective for people living with dementia, in aiding their orientation and helping them to be as independent as possible.

Is the service caring?

Good

The service was caring.

People who used the service told us they felt safe and cared for.

We observed staff interacting with people who used the service in a kind and considerate manner.

The service endeavoured to support people at the end of life according to their wishes, ensuring the people they wanted near them were there.

Is the service responsive?

Requires improvement

The service was not consistently responsive.

People's care plans were person centred and contained information about people's preferences and wishes.

Activities were limited and there was no activities coordinator in place which limited the number of things people could do.

Summary of findings

Some care records were not always accurately completed.

Is the service well-led?

Good

The service was well led.

There was a registered manager in place.

A number of audits were undertaken, issues identified and actions carried out.

Visitors told us they were made to feel welcome at every visit.

The service worked in partnership with other organisations.

Rivington View Nursing Home

Detailed findings

Background to this inspection

We carried out this unannounced 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 24 June and 25 June 2015 and was unannounced. The inspection team consisted of two adult social care inspectors and an adult social care inspection manager. At the previous inspection on 20 August 2014 the service was meeting all the standards inspected.

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 care plans and three staff personnel files. This included ten care files, pathway tracking of five care files and three medication administration records (MARS). We also looked at other documents kept in relation to the running of the home including audits and service and maintenance records. We spoke with three people who used the service, eight relatives and one professional 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. We also contacted the local Healthwatch to see if they had any information about the service. Healthwatch England is the national consumer champion in health and care. The Infection control and prevention team (ICPT) had recently completed an audit of Rivington View and the service had achieved a score of 92% compliance.

Requires improvement

Is the service safe?

Our findings

We spoke with three people who used the service. One person told us: "I like being here, I know people". Another person said: "I feel safe and cared for and there's never been a time when I didn't feel safe". A relative of a person who used the service told us: "The way (my family member) is looked after is great". Another relative said: "There is a good level of cleanliness in the home, which was an important part of me choosing Rivington View for my relative."

On arrival at the home we saw that one nurse and two care staff had been on duty through the previous night. Three people who used the service were up and out of bed and one person was wandering around the home without socks or footwear. There were no staff members present in the downstairs part of the home at this time. We heard two nurse call bells ringing for several minutes before staff responded to them, which meant that people who used the service had to wait for assistance.

Shortly after arrival at the home we heard a person using the service calling out from their bedroom. We informed a member of staff about this and they told us that the person does have a call bell, but it is usual for them to call out a lot in the morning. The staff member said the person had a preference to being supported by the day care staff and liked to get up at 8am. A short time later we could hear the person still calling out and now sounding more distressed until eventually care staff responded and provided assistance.

We spoke to two night care staff about staffing levels and they both said that the workload was usually fine but: "today was unusual" and highlighted that they had been very busy when we arrived at the home. We looked at staff rotas, which evidenced how many staff were on duty on the day of inspection. We saw that the staff rota corresponded with the actual number of people on duty on the day of inspection.

During the afternoon of the first day of the inspection, we observed care in the communal lounge. We saw that one person became increasingly agitated and then later settled a little after we engaged with them. There were no staff members in the immediate area to reassure and respond to this person's agitation and distress.

We found there was no formal system in place to determine staffing levels in relation to people's level of dependency of their care and support needs. The registered manager told us; "Staffing levels have increased of late and we're now recruiting for early shifts. We know there have been issues and we need more staff but I'm confident we can get them. We're getting there."

This was a breach of Regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to staffing levels because 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.

We saw that one bathroom contained quantities of pads and the toilet had a wheelchair stored in it. There was a hoist in the downstairs corridor that was plugged into the wall socket and charging, which created a potential trip hazard for people using the corridor. We found a downstairs fire exit had two walking frames and a wheelchair partially blocking the exit route. One bathroom had two mattresses stored in it. We informed staff about these issues and they said that the bathroom was not used. The manager later provided us with the minutes of a meeting that had been held with the owner following the date of our inspection and these showed that agreement had been reached to change the unused bathroom into a store room so that items in corridors could be removed thereby reducing the risks to people who used the service.

We looked at how the service managed risk to ensure people were safe. We looked at ten care plans, which included a number of risk assessments and the control measures required to manage the risk. We looked at ten accident report forms and all were completed appropriately including details of an outcome, for example, if the person attended hospital, if the GP was called, or if no injuries were sustained. Accidents and incidents were recorded via a paper based incident reporting system.

Five people who used the service who had incident reports completed following falls were pathway tracked, which is cross referencing care records, via the home's documentation. Each person had a falls risk assessment in place and remedial action had been taken to minimise the risk of people falling in the future. Incident forms were

Requires improvement

Is the service safe?

completed appropriately including details of any outcome. We saw that there had been consultation with the falls prevention team and safety measures had been put in pace such as hip protectors, bone protectors and crash mats.

The information in one care plan that we tracked was consistent with what we observed and with what the person who used the service told us. For example, we observed (this person) using their wheelchair with a lap-belt as outlined in their care plan and sitting outside in the sun, which was their preference for a period of time when the weather is nice.

We asked a care staff member about their understanding of safeguarding and they said: "I would report it to the nurse in charge." The staff member was confident about what safeguarding was. However, they thought the home would investigate such issues. On prompting they referenced the Local Authority and CQC. We checked the training records for this person and found that they had recently completed training in the safeguarding of vulnerable adults.

We looked at the recruitment records of three members of staff. Recruitment checks were undertaken before each staff member began work. We found evidence that identification had been confirmed, references obtained and evidence that a Disclosure and Barring Service (DBS) check had been carried out prior to the new member of staff working in the service. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults, to help employers make safer recruiting decisions and also to prevent unsuitable people from working with children and vulnerable adults.

We found the service had been working closely with the Infection Control and Prevention Team (ICPT) and had achieved a score of 92% compliance. We saw that a new mattress audit form had recently been introduced together with further training in infection control. One mattress had been replaced and we saw that the ICPT were arranging further training including Aseptic Non-Touch Technique (ANTT) for nurses. ANTT is the method used to reduce the risk of microbial contamination in a vulnerable body site. We saw that two members of staff shared the Infection Control (IC) Lead Nurse Role. We saw that a hand washing audit had recently been completed in May 2015 and there had been no infection control outbreaks since February 2015. Areas for improvement from the IC audit had been identified such as introducing a steam cleaning schedule for soft furnishings. The home was free from odours and clean throughout.

Three bathrooms were inspected on both the ground floor and first floor. Surfaces and toilets, including commodes, were visibly clean. Appropriate hand wash dispensers were available in each area and paper towels for hand drying were provided. Daily and weekly cleaning schedules were in place in addition to a 'deep clean' record book that identified areas such as bathrooms, communal areas, lifts and the dining room.

We looked at how the service managed medication safely and from our observations we saw the staff had a good working knowledge about medication and conducted medication rounds in a safe and effective way maintaining necessary documentation. We looked at the medication policies, including administration, ordering, covert administration (when medicines are administered in food or drink without the person's knowledge), disposal, dealing with errors and as and when required (PRN) medication. The home had completed medication audits in partnership with the Clinical Commissioning Group that informed clear action plans. Training records and competency assessments were in place for staff along with an induction process for new staff. The home had a system for error reporting and recording.

Requires improvement

Is the service effective?

Our findings

During the inspection we looked at what training staff had undertaken to support them in their job role. A relative of a person who used the service said: "I think that staff have the skills and knowledge to do their job". The registered manager told us that all new staff undergo a process of induction that is linked to the requirements of the National Minimum Data Set – skills for care. (NMDS-SC.) The NMDS-SC is an on-line workforce data collection system for the social care sector. We saw that nursing review forms were present in nursing staff personnel files. One note on a recent form completed by the staff member read, "Although I think the training we receive is adequate, I do feel we could benefit from advanced dementia training."

We looked at staff training records and the staff training matrix. We saw that training was on-going and frequent for all job roles and all care staff had completed a range of training courses in the previous 12 months including moving and handling, medication, and understanding dementia. 92% of care staff had completed training in the Safeguarding of Vulnerable Adults and DoLS. 75% of care staff had also completed training in the Mental Capacity Act. Catering staff had all undertaken relevant training in food hygiene. The registered manager and one care staff member were also undergoing training in the Care Certificate. The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working life.

The service worked within the legal requirements of the MCA and DoLS. MCA sets out the legal requirements and guidance around how to ascertain people's capacity to make particular decisions at certain times. There was also direction on how to assist someone in the decision making process. DoLS are part of the Mental Capacity Act 2005. They aim to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom.

We spoke to a staff member who said they had received basic Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) training. We verified this by checking training records for this person. They said there were people with a DoLS in place and others had previously had applications submitted. They highlighted that one person who used the service was on a DoLS but they were unsure as to why exactly that was.

We spoke with a visiting NHS healthcare worker who was attending on the day of inspection. They had no concerns regarding the home and said: "Care records kept by Rivington View relating to my specific clinical role are always up-to-date when I visit and any changes to a resident's condition are reported in a timely manner."

We observed the lunch time meal using a 'short observational framework for assessment' (SOFI). SOFI is used when reviewing services for people who have conditions that mean they cannot reliably give their verbal opinion on the services they receive. On the whole there was a relaxed atmosphere within the dining room and people who used the service were provided with a hot meal and an alternative choice was offered to those who had changed their mind or had a reduced appetite. A choice of hot and cold drinks was also offered. At the lunch time meal we saw that there were no disposable aprons available for staff to wear whilst giving out meals or whilst supporting residents with their nutritional needs.

We spoke to the chef who was a long standing member of staff and saw that they had a good personal knowledge of each person's individual dietary requirements. There was a formal record clearly displayed in the kitchen area that provided details of those people who used the service who had special dietary requirements such as those who were diabetic and those on soft diets.

There was evidence of a 'consent to care and treatment' form contained within each care plan which was a document that was being used to demonstrate where consent had been given to provide direct care. In each case, the 'consent' document had been signed by a family member with no clear record or audit trail of whether these decisions were being made in the individual's best interest.

We found that care plans did not always reflect the current needs of people who used the service. We saw that one care plan was contradictory in relation to diet and thickened fluids. This indicated a soft pureed diet and custard thick fluids were required but following a recent Speech and Language Therapy (SaLT) review this was no longer needed as of three months prior to the date of the inspection visit. The registered manager said all the care staff knew the person was no longer on thickened fluids but acknowledged the care plans had not been updated. We checked with the care staff serving the drinks about whether the person had thickened drinks. They said (the person) didn't have these anymore and told us that it had

Requires improvement

Is the service effective?

changed recently. The manager updated the care plan to reflect the correct position regarding nutrition and fluids for the individual during the inspection. The care staff later showed us the guidance that went round with the drinks trolley so care staff could check exactly how drinks should be thickened.

Overall the environment was not consistently effective for people living with dementia. There were no consistent adaptations such as contrasting handrails, directional signage or themed areas that would have assisted people to mobilise round the building or understand where they were if assisted by staff. We found that some doors, including those leading to bathrooms, bedrooms and storage areas did not have anything visual to identify where that door led. This would make it hard for some people living with dementia to find the bathrooms or their bedrooms. Several items of furniture were old and in need of replacement.

We recommend that the service reviews current best practice guidance on developing dementia friendly environments.

Good

Is the service caring?

Our findings

We asked people who used the service if they thought that staff were kind and caring. One person who used the service told us: "I feel safe and cared for. Staff listen to me and I feel I get respected." A relative of a person who used the service told us: "I have 100% plus admiration for Rivington View, all staff are good with me and (my relative) and I think (my relative) is safe and comfortable." Another relative said: "As a frequent visitor to see (my relative) I see how caring you all are. You treat all the residents with so much care and that's why they feel secure and settled."

We found people had been involved in creating their care plans. Consent forms related to the taking of photographs and sharing of information were signed by the person. This helped ensure people understood and had agreed with their care plans.

We saw that on each of the bedroom doors there was a sign that said 'Observe resident's dignity – please knock before entering.' We observed that this was happening on the day of inspection and heard staff talking respectfully to people who used the service whilst still in their bedrooms. There was a poster called 'Our Dignity Tree' on the notice board in the entrance hallway. This contained a wide variety of information about how to ensure good practice in dignity within the home.

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

An appropriate level of support was provided to those people who required help with eating and drinking. Support was provided on a one-to-one basis and was unhurried. Staff were caring and affectionate with the people they supported. It was clear that staff knew the people they were supporting and had developed an affectionate professional relationship.

We observed care in the home throughout the day. Relationships between people who used the service and staff members were very warm. Conversations were of a friendly nature and there was a caring atmosphere. Staff attitude to people was polite and respectful using their names and people responded well to staff interaction.

We saw evidence that people who used the service and their relatives were encouraged to raise concerns and make suggestions. We saw a variety of questionnaires were there was space for people to make their comments. The registered manager told us that in the past there had been attempts to hold formal meetings with the people who used the service, but these had proven ineffective because people in general did not want to discuss issues in a large group. Therefore feedback was sought on an individual basis or via a questionnaire.

The service was accredited with the Gold Standards Framework (GSF) in End of Life Care (EOL) for the period September 2013 to September 2016. GSF gives training to all those providing end of life care to ensure better lives for people and recognised standards of care. The registered manager told us that the impact of following this framework was that people who used the service were able to remain in the home until the end of life, which reduced the potential negative impact on the individual of moving to another establishment and also contributed to positive staff morale.

Requires improvement

Is the service responsive?

Our findings

The relative of a person who used the service said: "Staff respect me and (my relative) and always keep in contact if there are any issues. I've never had to complain." However another relative said that (their family member) who used the service had waited for 25 minutes for assistance with personal care one day. On another occasion they had found (their family member) to be wet and that there was a problem with people wearing other people's clothes.

We saw that there were a variety of 'thank you' cards displayed on a notice board in the upstairs lounge. One card from a relative of a person who used the service said: "Thank you for showing me the activity room you created, my (family member) would be pleased and a huge thank you for all the care and love you and the other staff gave my (family member) while they were at Rivington View". Another card said: "What you do doesn't go unnoticed, you are our angels and we thank you each and every day from every inch of our hearts."

The service had a complaints policy and procedure. This required updating to include up to date information about CQC's role in relation to complaints. We checked the complaints file and found the service responded to and investigated complaints in line with their policy. A copy of the complaints procedure was included within the residents admission pack and there was a copy in each person's bedroom and on the wall in the public space. We asked people if they knew how to complain and most people told us they would speak with the registered manager. One person who used the service said: "I would go to the office if I was worried." The relative of another person who used the service said: "I have never had to make a complaint but would know where to go."

The service had previously employed an activities coordinator, but this role was vacant on the date of inspection due to the staff member taking up another role within the home and we saw that there were limited activities taking place on the day of inspection. Therefore people who used the service had a limited choice of activities to take part in.

We observed what was happening in the lounge in the afternoon of the first day of the inspection. With the exception of the one person receiving nail care, throughout the observed time period no other social or personal interactions took place. Whilst the interactions of care staff with people were kind and caring; they were focused on care tasks such as hoisting. People were sat in chairs around the edge of the room, with the television on at the other end. This meant that people were largely unengaged in meaningful activity throughout the 30 minute observed time period. We saw that several people who used the service remained seated for a large part of the day in the hallway entrance area.

There was a notice board in the activities room, which displayed photographs of people taking part in various activities. A hairdresser visited Rivington View on a weekly basis. The same hairdresser had been visiting for a long time and had a good rapport and understanding of the support needs of the people who used the service. 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.

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

Care plans of five people who used the service were case tracked. On the whole care plans contained a good level of detail but lacked a person centred approach. The approach to developing care plans was predominantly focussed on people's medical needs as many people who used the service required nursing care. There was no evidence around how residents, if able, were supported to make time or situation specific decisions.

We saw that one person in the lounge had visibly dirty finger nails with debris present. We asked the registered manager about this person. We highlighted the person's nails and the manager said (the person who used the service) could be very resistive to personal care. We asked what care plan was in place to manage this and found there was no care plan in place. The information in the care plan said '(the person who used the service) requires full assistance with hygiene needs, has non-compliance, verbal and physical aggression.' We looked at this person's daily notes and saw an entry 'Middle finger on right hand nail broken. Nail removed small amount of bleeding.' The manager said staff would look to address this. There was no evidence from either the care plan or the manager that steps had been taken to assess, monitor and plan care to manage the person's resistance to personal care.

Requires improvement

Is the service responsive?

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 not been updated since the person was admitted to the home. Care plans also contained information on family and social history.

This was a breach of Regulation 9 (1) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 - person centred care.

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. This left the form open to interpretation and the validity of the form open to challenge. Consequently five DNACPR forms were reviewed and several errors and omissions were identified including no valid diagnosis or medical reason for DNACPR, the form was not dated by the relevant GP, there was incorrect and contradictory information recorded regarding who had been consulted. Additionally, within each care plan that we reviewed, there was no clear documentary evidence as to how a DNACPR decision had been reached and no evidence of these decisions being made as part of a multi-disciplinary / best interests approach. The registered manager took prompt action to address this issue. We have followed this up outside of the inspection process.

Good

Is the service well-led?

Our findings

There was 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 spoke with three members of staff about their experiences of working at Rivington View. One staff member said: "I really enjoy it." Another staff member told us: "Communication between staff and nurses is good." They also said they felt the registered manager listed to them and supported them in carrying out their job role. Another staff member said: "I'm happy with management."

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 registered manager.

We looked at the Quality Assurance Policy, dated March 2008, and saw that there were two questionnaires within the policy. One questionnaire was a service user satisfaction questionnaire and one was a visitor questionnaire. Comments on the visitor questionnaires we looked at included: "I am always made to feel welcome every time I visit. Always smiles," and: "Staff are like friends and I've never needed to make a complaint". Comments on questionnaires from people who used the service included: "My bed is comfortable and warm and I am well looked-after. The staff are very friendly; the meals are good and varied."

We looked at staff questionnaires, which the manager used to gather feedback and ideas. We saw that one response identified the need for new chairs in the lounge and we found that these had been purchased. This demonstrated that the manager had appropriately responded to the views of the staff members. We saw a questionnaire for relatives of people who used the service and one form said: "I am made to feel welcome every time I visit."

There was also a Quality Assurance Audit Form in place. Equipment service audits were all in one file and well organised with an overarching list of activity, the last date of service and when the next one was needed for example Legionella; Argo bath; Gas safety; Dryer; Hoists; Syringe drivers; PAT testing (Portable Appliance Testing); Fire alarm and fire extinguishers.

We spoke with the registered manager about the process for care plan audits. The registered manager was able to demonstrate that in the past the service had been auditing all the care plans over a three month period. As of June 2015, the service had changed this process and now audited a sample of five care plans per month. These individual audits were within people's care plans.

We found that regular service audits were being carried out by the service. We tracked two audits and found that the process had been followed correctly and the manager had signed-off actions from the care plan audit as complete. We saw a record dated April 2015 – 100% of staff fire trained and 'weekly checks maintained'; Kitchen checks in place; cleaning schedule in place (upstairs and downstairs).This demonstrated that the system was effective as actions were being set, completed and signed-off.

We looked at environmental audits and checks and found that an audit had been carried out on 06 June 2015. This audit considered several bedrooms, the downstairs lounge and the downstairs corridor. Three further sets of these audits were available from 2014.

There was a 'daily cleaning task' information sheet available in the kitchen giving clear instructions about the process for cleaning the kitchen area. A 'sign and date' sheet was also available and fully completed. A fridge temperature record was available and this was fully completed and up-to-date.

In collaboration with the local Clinical Commissioning Group, we saw that Rivington View had recently undertaken a significant piece of positive work around cleanliness and infection prevention and control. 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, Chiropodists and Doctors and NHS Community Health workers.

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	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The care people received did not consistently meet their needs and reflect their preferences. Regulation 9(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing 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. Regulation 18(1)