Ilkley Health Care Limited

Riverview Nursing Home

Inspection report

Stourton Road
Ilkley
West Yorkshire
LS29 9BG

Tel: 01943602352

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

The inspection took place on 19 December 2017 and 4 & 24 January 2018. All the visits were unannounced. On 19 December 2017, there were 47 people who used the service; on 4 January 2018, there were 45 and on 24 January 2018, there were 44.

Riverview is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The care home accommodates 60 people in one adapted building. Accommodation is provided over four floors.

The last inspection was carried out in June 2017 and the overall rating for the service was 'requires improvement'. The provider was in breach of four Regulations. These related to staffing (Regulation 18), staff recruitment (Regulation 19), meeting people's nutritional needs (Regulation 14) and good governance (Regulation 17). We took enforcement action and issued warning notices in relation to the breaches of Regulation 14 (nutrition) and Regulation 17 (good governance). We issued requirement notices in relation to the breaches of the staffing and recruitment Regulations. We met with the provider to discuss their plans for making the required improvements to the service. We informed the provider we were concerned this was the second consecutive inspection when the overall rating was 'requires improvement'. The service was rated 'requires improvement' in June 2016. We asked the provider for an action plan and they have sent the Commission monthly updates on their action since then.

During this inspection, we found improvements had been made in relation to supporting people to meet their nutritional needs. However, we found other areas of the service had not improved. In addition to two continued breaches of Regulations in relation to staffing, and good governance we identified five new breaches of Regulations. These related to safe care and treatment, consent to care and treatment, person centred care, dignity and respect and the cleanliness of the home.

Since the last inspection in June 2017, there had been a change of registered manager. The new manager was registered by CQC in December 2017. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

There were not enough staff deployed to meet people's needs. On the first day of our inspection, we found staff were routinely getting people from 5am without any evidence to show this was what people wanted or was in their best interests. This improved over the course of the inspection. However, we were concerned the provider had not identified or addressed this, particularly as we had made then aware of concerns about staffing levels at the last inspection.

We found care was not always delivered in a way which was appropriate to people's needs and people were

at risk of receiving care which was not safe. People's care records were not up to date and did not provide staff with information about their individual needs and preferences.

People told us they felt the service was safe. Staff had received training on safeguarding; however, they needed more support to understand how to apply this training in their day to day work.

There were recruitment procedures in place but we were unable to test how well they worked because no new staff had been employed since our last inspection.

On the first day of our inspection, we found the home was not kept free of unpleasant odours. We found risks to people's health and safety were not always identified and managed. More needed to be done to create a 'dementia friendly' environment; the provider told us they had started work on this.

We found people's medicines were managed safely.

People's rights were not always protected. The service did not always ensure relatives who made decisions on people's behalf had the legal authority to do this.

We found the staff were caring and kind. However, we observed some working practices that compromised people's dignity and were not respectful.

People were supported to meet their nutritional needs and were offered a variety of food and drink. We found people were supported to meet their health care needs and had access to the full range of NHS services.

People were given the opportunity to take part in a range of social activities.

We saw complaints had been investigated. The information given to people in the complaints procedure was not accurate. We had raised this with the provider at the last inspection.

The provider had systems in place to monitor and assess the quality and safety of the service. However, we found these systems were not effective because they had not prevented the issues identified during this inspection.

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

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

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

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

operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Most people felt the service was safe, however we had a number of concerns which led us to conclude the service was not safe.

There were not enough staff to meet people's needs in a timely way.

Although staff had been trained they did not always recognise and report safeguarding concerns.

Risks to people's health, safety and welfare were not always identified and managed.

People's medicines were managed safely.

The home was not always clean and free of unpleasant odours.

Is the service effective?

Requires Improvement

The service was not consistently effective.

The service did not always ensure relatives who made decisions on people's behalf had the legal authority to do this.

Improvements had been made to the way people were supported to meet their nutritional needs.

Staff received training to help them carry out their roles.

People were supported to meet their health care needs and had access to the full range of NHS services.

More needed to be done to create a dementia friendly environment for people.

Is the service caring?

Requires Improvement

The service was not always caring.

We saw some good, caring interactions between staff and people

who lived at the home.

Some practices showed a lack of respect for people.

People's relatives were involved in decisions about care and treatment.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People did not consistently experience care and treatment which was appropriate to their needs.

People's care plans were not always person centred or complete which created a risk their needs would not be met. The provider was dealing with this but the pace of progress was slow.

People were offered the opportunity to take part in a range of activities.

Complaints were investigated and the majority of people were satisfied that their concerns were listened to and acted on. The information provided to people in the complaints procedure was not accurate.

Is the service well-led?

Inadequate

The service was not well led.

Although the provider had quality monitoring systems in place they had not been effective in achieving the required improvements in the service since April 2016.

People's relatives told us they were generally satisfied with the service provided and would recommend the home.

Riverview Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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 inspection was carried out in response to information of concern we received about the service. The concerns were mainly related to staffing levels and the impact this was having on people's care.

The inspection took place on 19 December 2017 and January 4 and 24, 2018; all the visits were unannounced.

The inspection team consisted of three adult social care inspectors in total; there were two inspectors on every visit. On 19 December 2017 the inspection team included an expert-by-experience. In this case the expert was experienced in the care of older people and people living with dementia.

Before the inspection we reviewed all the information we had about the service; this included notifications sent by the home manager and information we received from members of the public. We contacted the local authority commissioning and safeguarding teams to ask for their views about the service.

The provider has met the minimum requirement of completing the Provider Information Return at least once annually. Their last Provider Information Return was submitted in April 2017. The PIR gives us information about the service what the service does well and improvements they plan to make. In addition, since our inspection in June 2017 the provider has been sending us monthly updates on their action/improvement plan. We reviewed this information as part of our inspection planning.

During the inspection we spoke with four people who used the service and five relatives. We looked at eight people's care plans and looked at other records such as the daily care notes completed by care staff. We looked at medicines records, staff training records, meeting notes and other records related to the day to day running of the home such as maintenance records. We spoke with four nurses, seven care workers, the cook, one of the housekeeping staff, the registered manager and one of the directors. We observed people

being supported in the communal rooms and looked around the home at a selection of bedrooms and communal bathrooms and toilets.

Inadequate

Is the service safe?

Our findings

At the last inspection in June 2017, we found the provider was in breach of Regulation 18 (Staffing) because there were not enough staff deployed to meet people's needs in a timely way.
Before the inspection in December 2017, we received information that staff were getting people up as early as 5am because there were not enough staff. During the inspection, we found there were not enough staff deployed to meet people's needs and the provider remained in breach of Regulation 18. We asked people who used the service about staffing and their responses were mixed. One person said, "I don't really know." Another person said, "Sometimes they are short staffed. Sometimes I have had to wait two hours before they came. I have wet the bed occasionally. It seems to be worse early morning."

Relatives we spoke with also had mixed views about staffing. One relative said, "Yes there is enough staff." Another relative said, "There is not enough staff, there has been a high turnover of staff. I do think it will improve."

On 19 December 2017 at 7.15am, we identified 19 people who were up and dressed. The night staff told us, they had started getting people up at 5am. The records confirmed this and showed it was not an isolated example; night staff were routinely getting people up from 5am. When we asked staff why they started getting people up so early they said it was because they were awake. In the absence of any evidence to show this was in people's best interests we concluded this practice was for the convenience of staff.

On 4 January 2018, we arrived at the home at 6.30am and found most people were still in bed and asleep. There were nine people up, two of whom had been up all night. We found that because day staff were supporting people to get up and dressed there were not enough staff to support people to have their breakfast in a timely way. For example, in the first floor lounge we observed one care worker was supporting eight people who all needed assistance. In the case of one person, it took the care worker 30 minutes to support them to eat a bowl of porridge. During that time, they had to break off on at least three occasions to support other people. Some people were still having their breakfast at 11am and when it came to lunchtime, these people did not want to eat again.

On 19 December 2017, we observed the mealtime service at lunchtime. We found there were not enough staff deployed and this resulted in a poor mealtime experience for people. For example, staff told us lunch was served between 12.30 and 1pm. We went into the dining room at 12.55pm and saw most people were already sat at their tables. Lunch was not served to people until 1.20pm. We saw that several people had become anxious while waiting.

On 4 January 2018, we found this had been addressed and housekeeping staff had been enlisted to help with the meal service. However, the provider had not reviewed the deployment of staff at breakfast time to reflect the fact that people were staying in bed later. In the first floor lounge, we observed there was one member of staff to support seven people, all of whom needed some degree of help, with breakfast. The care worker was kind and encouraging but they were unable to give people the support they needed in a timely way. For example, one person was sitting at the table attempting to eat their porridge; they got porridge on

their fingers but did not have a napkin to wipe clean them. We intervened to give the person some tissues, which were out of reach on the mantelpiece. The care worker was supporting another person to eat and was able to see the person needed help. Another person had porridge on their face and chin for 55 minutes before staff supported them to clean their face.

During the inspection on 4 January 2018 at approximately 9am, one of the inspection team visited a person in their bedroom. The person said they had not had any breakfast and the inspector suggested using the call bell. The person said there was no point because, "They never come." The inspector activated the call bell and waited outside the room. After approximately ten minutes, the call bell stopped ringing but no staff member had attended to the person. After another five minutes, the inspector went downstairs and asked the nurse in charge to send a member of staff to the person's room.

This was a continued breach of Regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We were concerned the call bell had been cancelled without a member of staff going to the room. We discussed this with the provider and registered manager and asked them to investigate how the call bell had been turned off without anyone going to the room.

We made a further unannounced visit to the home on 24 January 2018. We arrived at the home at approximately 6.30am we found there were two people up and dressed in downstairs lounge. We looked around the home and found other people were asleep in bed. We found the meal service at breakfast time had improved. The registered manager had made changes to the morning routine and many people were now offered the opportunity to have their breakfast in bed. We also saw housekeeping staff were helping people with their breakfast. Staff told us the changes to the morning routine were working well and many people were enjoying having their breakfast in bed.

At the last inspection in June 2017, we found the provider was in breach of Regulation 17 (Good governance) because they did not have effective process in place to assess, monitor and mitigate risks to the health, safety and welfare of people who used the service and others. During this inspection, we found that although the provider had taken action to address the specific risks identified during the last inspection they remained in breach of this Regulation. For example, we found there were still not enough staff deployed and the provider remained in breach of Regulation 18. This showed they had not acted on feedback and learned lessons following our last inspection.

In another example, we saw some of the routine tests of the fire alarm system and emergency lighting were not up to date. The service required the emergency lighting to be tested every month; however, the last recorded test was May 2017. We were told the fire alarm system was tested every week on a Thursday; however, the last recorded test was 25 September 2017.

When we looked around the building, we noted the lobby area on the first floor was being used for storage. There was a fire exit in this area, so for safety reasons this area should have been kept clear.
This was a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We referred our concerns to West Yorkshire Fire & Rescue Service. When we went back to the home on 24 January 2018, we found these issues had been addressed. However, the provider's monitoring systems should have identified these concerns.

We saw Personal Emergency Evacuation Plans (PEEPs) had been completed for people who used the service. However, we saw one person's moving and handling needs had changed since the PEEP had been completed. Their PEEP stated they needed one person to help them transfer into a wheelchair. However, their needs had changed and they needed the assistance of two people to help them to transfer. We identified a further two PEEPs which were not up to date.

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

There were processes in place to make sure accidents and incidents were recorded. In most cases we found appropriate action had been taken following accidents and incidents for example, medical advice had been sought and relatives had been informed. However, we found on one occasion an accident had not been reported and only became known when the person was found to have old bruising. The registered manager carried out an investigation and had taken action to reduce the risk of this happening again.

On the first day of our inspection, we found the home was not clean and free from unpleasant odours. There was a smell of urine in the entrance to the home and in some of the communal areas such as the hallways. We found some chairs smelled of urine. In one of the lounges, we saw there was a spillage on the floor near where people were sitting. The floor was not mopped during the time we sat in the lounge. In the same lounge, we saw some of the small tables, which were in front of people, were smeared and were unclean. Just before lunchtime on the same day, we saw a person walking towards the dining room in their stockings leaving a trail of wet footprints behind them. We brought this to the attention of staff who then provided the person with appropriate support. . However, we observed the floor was not mopped. This meant the home was being kept clean and odour free.

One person we spoke with said, "I don't think a lot to the accommodation. They don't keep it as clean as the other places where I lived in." Relatives we spoke with had mixed views about the cleanliness of the home. One relative said, "The environment is quite pleasant and it is always improving and it's clean enough." Another relative said, "Sometimes it could do with cleaning better, but on the whole it's not bad."

On the second day of our inspection, we found that while there had been some improvement there were still unpleasant odours. For example, there was an unpleasant odour in one of the bathrooms and when we looked in the bin; we saw soiled incontinence pads had not been put into plastic bags before being put into the bin.

On 19 December 2017, we found two peoples' mattresses had a strong unpleasant smell of stale urine. On 4 January 2018, we found the mattresses had been replaced. However, although the smell was not as strong as it had been they still smelled of urine. This could be due to the mattresses not being cleaned properly and/or people's continence needs not being managed effectively. This was discussed with the registered manager.

This was a breach of Regulation 15 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

When we visited the home on 24 January 2018, we found there had been an improvement in relation to the management of unpleasant odours in the bedrooms we checked. The registered manager told us people's continence needs had been reassessed.

At the last inspection we found the provider was in breach of Regulation 19 (Fit and proper persons) because

their recruitment procedures had not been followed. During this inspection, we found no new care staff had been employed; two staff had transferred from other locations operated by the provider. The registered manager told us they were in the process of recruiting to fill vacancies for care staff but had not appointed anyone as they were waiting for criminal records checks and references. The registered manager told us they had carried out an audit of the staff files for existing staff and were dealing with the shortfalls. They told us they would have completed this by the end of January 2018. The registered manager said they had reviewed the provider's recruitment policy and assured us recruitment would be carried out in accordance with the policy in future. We were unable to test this during our inspection.

There were mixed responses when people were asked if they felt safe living at the home. One person said, "Oh, yes I do feel safe here. I have a call bell and they [staff] come quick enough."
Another person said, "Often residents come into my room. I don't like a locked door, and I am unable to lock my door myself anyway."

Relatives we spoke with told us they felt their relatives were kept safe at the home. One relative said, "My [relative] is definitely safe here. [Relative] could not look after herself and the staff look after [relative]."
Another relative said, "I know [relative] is safe when I am not here."

We saw information about safeguarding was available outside of the nurse's office and staff told us they had received relevant training. However, we concluded staff needed more support to help them recognise and report safeguarding concerns in their day to day work. During the second day of our inspection, we observed an incident between two people who used the service. We saw staff quickly intervened to deal with the situation. However, despite there being physical contact and one person being clearly distressed by the encounter staff did not report this as a safeguarding concern. The registered manager was only made aware of the incident when the inspectors raised it and they subsequently completed the relevant reports.

The service held money, for some people who used the service, for safekeeping in the office. We looked at the individual records and saw receipts had been obtained for any purchases that had been made. We crossed referenced the money held for two people with the transaction sheets and no concerns were identified. This showed us people were being protected from any financial abuse.

Both people we spoke with told us they received their medicines, which were administered by staff. One person said, "The staff give me my tablets. I get them approximately on time." Another person said, "The nurse gives me my medication. I sometimes get it on time; not always."

The clinical lead nurse explained people's medicines were kept under review with their GP. These reviews ensured people were not taking medicines which were no longer needed and medication was kept to a minimum.

We saw medicines were stored in locked trolleys, cabinets or fridges. The nurses took responsibility for administering medicines and we saw them doing this with patience and kindness. We looked at a sample of medication administration records (MARs) and saw people were being given medicines as prescribed. When medicines had been prescribed to be taken 'as required' there were detailed instructions for staff to follow. This helped to ensure these medicines were used effectively and consistently. We concluded medicines were stored, managed and administered safely.

Requires Improvement

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We saw one person had been granted a DoLS authorisation for a three week period, which had expired in November 2017. We saw there had been very specific conditions attached to the authorisation; however, we could find no evidence in the care file of these having been met.

We saw two people's consent documentation had been signed by a relative. The relatives did not have Lasting Power of Attorney (LPA). A LPA is a legal document that allows someone to make decisions for you, or act on your behalf, if you're no longer able to or if you no longer want to make your own decisions. LPAs can be put in place for property and financial affairs or health and welfare. Without an LPA for health and care the relative did not have the authority to do this. We made the provider aware of the importance of having information about LPAs at the last inspection in June 2017.

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

We spoke with an Independent Mental Capacity Advocate (IMCA) who supported one person who used the service. They told us they were satisfied the service provided appropriate support and respected the person's lifestyle choices.

The clinical lead nurse assured us people's needs were assessed before they moved into the home. In most cases the records of these pre-admission assessments were available.

Overall, relatives felt people's needs were being met by care staff. One relative said, "[Relative] looks better now than [person] has ever done." Another relative said, "All we can say is that we are quite happy with everything here." A third relative said, "I am happy with [name] being here as [person] is well looked after."

The registered manager told us they had reviewed all the staff training. The training matrix confirmed training on safe working practices had been provided. We saw further training sessions had been booked. For example, training was scheduled for practical moving and handling and end of life care in January and February 2018. Most of the training was delivered in house by a trained trainer and the registered manager told us they were moving to an electronic training system to make it easier for staff to complete training

updates annually.

The registered manager told us new staff had been provided with a detailed induction. For staff with experience in care this was an in-house induction. Staff with no previous experience attended formal induction training with an external training provider. The registered manager told us they did not offer new staff the opportunity to complete the Care Certificate. This is a nationally recognised induction training programme for staff with no previous care experience or qualifications.

The registered manager told us staff appraisals were carried out annually and were planned for the year. Since taking up their post the registered manager told us they had carried out at least one supervision meeting with all the staff. Further supervision meetings had been scheduled.

At the last inspection in June 2017 we found there was a risk people's nutritional needs were not being met and the provider was in breach of Regulation 14, meeting nutritional and hydration needs. On this inspection we found they had made improvements.

People who used the service and relatives told us the meals at the home were good. Their comments included, "The food is ok we have a good chef", "The food is not too bad", "I help my [relative] with [person's] lunch. [Person] does like [person's] food and [person] is well fed", "Food wise, they get well looked after."

Staff told us there was a constant supply of food and snacks and our observations confirmed this. One care worker said the food was good and staff ate at the home.

People who had been assessed as being nutritionally at risk were being weighed every week. Also records were being maintained of what they were eating and drinking. We found these records were well completed and showed people were being offered high calorie snacks and drinks in line with their care plans. We spoke with a GP who told us they had seen an improvement in the way people's nutritional needs were identified and met.

The chef told us they fortified food for everyone. We judged this was not the most effective way of making sure people's individual nutritional needs were met. For example, one person, who was not nutritionally at risk, had put on 3.8kgs in two months. Their Body Mass Index (BMI) was 42, which indicated they were obese. BMI is a recognised tool used to calculate whether people are within a health weight range, are underweight or overweight. We discussed this with the registered manager and clinical lead nurse who agreed they would carry out a review to ensure people's individual needs were met.

One person we spoke with told us they had not needed any intervention from other health care professionals. Relatives we spoke with confirmed that health care professionals were called when needed. One relative said, "In hospital they could not control my [relative's] diabetes. They maintain [person's] diabetes well here. I think the medical side here is really good. They keep me informed if [relative] becomes unwell. They telephone me." A second person told us, "[Name] has only been ill once in the four years [person] has been here; they [staff] got the doctor. That shows that [person] is well looked after."

In the care files we looked at we saw people had been seen by a range of healthcare professionals such as GPs, community matrons, psychiatrists, opticians and podiatrists. We noticed two people with diabetes had high blood sugar levels recorded. The visiting GP was fully aware of this and explained the reasons for this. This showed us staff had kept them up to date with information. This provided assurance the service was working with other professionals and organisations to support people to meet their health care needs.

Overall we found very little had been done to create a 'dementia friendly' place for people to live. One of the small lounges had been equipped with household items such as a washing machine to support people carry out household chores but little else had been done to create a stimulating and enabling environment for people. The provider told us they had identified this and had engaged the services of an outside company to help improve the environment for people.

Requires Improvement

Is the service caring?

Our findings

We saw some practices which showed a lack of respect for people. For example, at breakfast time one of the housekeeping staff was mopping the floor and then sprayed and cleaned the walls. The smell of the cleaning products was very strong and not appropriate whilst people were eating.

On 19 December 2017, we found two mattresses people had slept on smelt extremely heavily of stale urine. One of the nurses agreed this was unacceptable. When we visited the home on 4 January 2018, we saw some mattresses had been replaced but there were still problems with odour management. We discussed this with the registered manager and when we returned on 24 January 2018, we found improvements had been made.

When we looked around the home we saw the towels in some people's bedrooms were old and frayed around the edges. The housekeeper told us they were old towels used for hairdressing and should not have been put in people's bedrooms.

In the records of another person who was living with dementia we saw they liked to wear feminine clothes, have their nails polished and wear lipstick. We saw the person was wearing trousers, their nails were not polished, they were not wearing lipstick and their hair had not been brushed.

We saw one person had a runny nose, there were no tissues available and a care worker got them some paper towels.

At lunchtime, we observed the dining tables had tablecloths but no condiments, sauces, cutlery or serviettes.

We found people were not always supported to maintain their independence. For example, while observing lunch on 19 December 2017 we did not see any adapted utensils or plate guards to help people eat on their own. We observed the person we sat with could have benefited from a plate guard as they pushed their food around their plate and onto the tablemat and tablecloth.

In another example, on 4 January 2018 we saw a care worker give one person who used the service a bowl of porridge and then walk away. The person picked up the bowl and lifted it to their mouth trying to eat the porridge. There were no staff present. One of the inspectors went and placed the bowl back on the table and gave the person a spoon. The person started to eat their porridge; however, every time they lifted the spoon about half of the porridge fell off the spoon. We asked one of the care workers if they had any adapted cutlery. They told us they did not but added they thought the person would benefit from this.

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

People we spoke with told us they thought that the staff were kind and caring. One person said, "Staff are quite good." Another person said, "Some of the staff are okay. I don't like the agency staff as they don't know what they are doing." One person who lived at the home told us staff always knocked on their door before entering their bedroom; they added, "They maintain my privacy and dignity when helping me to shower as they keep my door closed."

We observed some good, caring and patient exchanges between staff and people who used the service. For example, when the day staff came on duty and were early for their shift, they spoke with people in the lounge, offered them drinks and some staff sat and chatted with people whilst they too had a drink. Care workers were mostly very good at speaking with people and clearly had a good knowledge of people's life history and individual interests.

On the second day of our inspection, the lunchtime mealtime experience for people had improved. In one lounge a care worker was sitting at the dining table with four people. They assisted one person with their meal whist prompting another person to eat. There was a lot of chatting and a nice relaxed atmosphere.

Relatives told us they could visit at any time. One relative said, "I do like coming here." Another relative said, "The staff have always been good. The level of standard of care is good. I do think [relative] is happy enough."

The care records showed people's relatives were involved in decisions about their care and treatment. One person who used the service said, "I know I have a care plan somewhere. I don't know anything about a review."

We looked at whether the service complied with the Equality Act 2010 and in particular how the service ensured people were not treated unfairly because of any characteristics that are protected under the legislation. Although we found no evidence people were discriminated against we found there was sometimes a lack of attention to detail in ensuring people's individual needs were met. For example, one person's records stated they should wear spectacles; we saw they were not wearing spectacles on any of the days we visited despite the fact we asked staff about this on the first day of our inspection.

Requires Improvement

Is the service responsive?

Our findings

We found people were not consistently receiving care and treatment which was appropriate to their needs and reflected their preferences.

Before the inspection we received information from a member of the public who told us staff started getting people up at 5am because of staff shortages.

On 19 December 2017 at 7.15am, we identified with a care worker the names of 19 people were up and sitting in the ground floor lounge. Staff told us they started getting people up from 5am and this was confirmed by the records. The records also showed this was not an isolated incident and staff were routinely getting people up as early as 5am. When we asked staff why they were getting people up so early they said it was because people were awake. There was no evidence within people's care records to show it had been agreed it was in their best interests to get up so early.

On 4 January 2018, we arrived at the home at 6.30am and found most people were still in bed an asleep. We saw the notes of a staff meeting that had been held on 20 December 2017 in which the registered manager had instructed staff to continue to dress people who were awake at 5am in their day clothes and leave them in bed. We concluded this was to save staff time and not in response to people's needs.

On 19 December 2017, we observed the mealtime process at lunchtime was poor. People were shown two plates of food to help them decide what they wanted for lunch. One care worker showed the two plates whilst another care worker made a list of what people wanted. There was then a significant delay before people received their meal. In one lounge there were four people sat at the dining table. One person was saying, "Give me my dinner, dinner, dinner, dinner," and was ignored by one member of staff. Five minutes later, they were asking the same question and were told by a care worker, "Be patient for a few minutes longer." Five minutes later they were asking the same question and one of the nurses replied, "I'll go and see where it is, [name]", to which the person replied, "It might even be in the kitchen." Five minutes later staff brought the person's meal.

On the same day we observed the lunch time meal service in the large dining room. There was one care worker and eleven people who used the service in the dining room. Staff told us lunch was served between 12.30 and 1pm. We went into the dining room at 12.55pm and saw most people were already sat at their tables. Lunch was not served to people until 1.20pm. We saw that several people had become anxious while waiting. One person put their leg onto a chair and began pouring their orange juice over their leg. The member of staff intervened and the person became distressed and hit out at them. Another member of staff arrived and both of them reassured the person. Another person kept standing up, sitting down and then moving to another chair. Another person was repeatedly asking where the food was.

On 4 January 2018, we observed the meal service at breakfast time in the lounge of the first floor. There was one member of staff supporting seven people. The care worker was supporting one person who was sitting in an armchair to eat. Another person was sat at the table attempting to eat their porridge; they got porridge

on their fingers but did not have a napkin to wipe them. We intervened to give the person some tissues that were out of reach on the mantelpiece. The care worker had their back to the table and was not in a position to see the person needed help. The care worker was kind and spoke with people gently encouraging them to eat. However, they were unable to support everyone in a timely way. For example, we saw one person had porridge on their face and chin; it was 55 minutes before this was dealt with by staff.

On the second day of the inspection we found two people had spent the night sleeping in the lounge. One person was asleep across two easy chairs which had been pushed together. The other was asleep in an arm chair. Staff explained one of these people rarely went to bed. Arrangements had not been made to make sure people had suitable chairs to sleep in and to afford them more privacy.

We spoke with a visiting healthcare professional who told us they had seen an improvement in recent months in the way people were supported at the end of life. They said this was supported by feedback they had received from people's relatives.

The registered manager provided us with a copy of an end of life plan, which was put into place for the last days of life. They also provided us with a copy of an End of Life Decisions form designed to record people's wishes about the way they wanted to be supported at the end of life.

However, this was not supported by the care records we looked at which created a risk people at the end of life would not consistently experience care which was appropriate and took account of their preferences. For example, one person's care plan stated they wished to remain at Riverview, be treated withdignity and respect and be pain free. The name of the funeral director was recorded but there were no details about how the person wanted to be cared for at the end of their life. Another person's care plan stated, "Family have not discussed what they wish to happen when [person's] dying process begins."

We found people's needs were not properly assessed to make sure they received appropriate care and treatment, which met their needs. For example, we saw people had not been provided with adapted cutlery and/or utensils to support them to maintain their independence.

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

We found people were at risk of not always receiving safe care and treatment. Some people who used the service had specialist mattresses on their beds. These had been put in place to reduce the risk of them developing pressure damage to their skin. However, we noted some of these mattresses were not on the correct settings for people's weights. For example, one person weighed 88.50kgs but their mattress was set at a therapeutic level for 30kgs. Another person weighed 76kgs and their mattress was set at a therapeutic level for 160kgs. If these mattresses are not on the right setting their therapeutic value can be lost and increase the risk of tissue damage. No one who used the service had pressure sores at the time of our inspection.

In another person's records, we saw they should have a sensor mat and crash mat in their bedroom because they were at risk of falls. When we looked in the person's room we found there was a sensor mat but no crash mat in place.

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

When we visited the home on 24 January 2018 at approximately 6.30am we found all but two people were in bed. In addition, we found the two people who had been sleeping in armchairs in the lounge were sleeping in bed. Staff told us they had spent more time with the two people concerned, providing support and encouragement until they had settled into bed.

At the last inspection in June 2017, the provider told us they were aware people's care records were not always accurate and up to date. They told us they were taking action to address this. During this inspection, we found work was in progress to put up to date, person centred care plans in place for everyone who used the service. However, we were concerned about the length of time this was taking.

One of the care plans we looked at stated the person could be aggressive and needed reassurance. There was no further information about what reassurances worked well or any detailed guidance for staff to follow.

We looked at the records of a person who was living with Parkinson's disease and taking medication. There was no care plan in relation to this to make sure staff knew why it was important for them to have their medicines at the same times every day.

This was a continued breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Within the care records we saw people's communication needs were assessed. The registered manager told us they had identified one person who had particular communication needs and explained what they were doing to support the person. They told us they had not yet attended training about the Accessible Information Standard.

During the morning of 19 December 2017, we did not see any activities taking place. In the afternoon entertainment was provided by a group of carol singers and bell ringers. Planned activities were displayed and included a date for the Christmas party, visits from a local guides group and a local primary school and hairdresser visits.

We asked people about activities in the home. One person said, "I stay in bed in my room all of the time as there is nothing to do. I watch TV a lot if there is anything on. I am getting Sky TV in the next few weeks."

Copies of the complaints procedure were available from outside of the nurse's office. The procedure contained some inaccurate information about CQC's role in relation to complaints. At the last inspection in June 2017, we made the provider aware the information given to people about the role of CQC in dealing with complaints was inaccurate. This showed the providers governance systems were not being operated effectively. .
This was a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People who used the service told us if they had any concerns or complaints they would tell the registered manager or a member of staff. Relatives told us, "[Name of registered manager] is on the ball. I would go to [name of registered manager] if I had any concerns or a complaint." Another relative said, "I have no worries or concerns."

The registered manager told us there had been two complaints and these had been sent to the local authority safeguarding team. A log of any concerns or low level complaints was not maintained. This

information is helpful in identifying trends and patterns and can be used to help bring about improvements.

Inadequate

Is the service well-led?

Our findings

We have rated this domain inadequate because the service has had an overall rating of 'requires improvement' since April 2016. In April 2016 we found the service was in breach of three Regulations; Regulation 13 (safeguarding), Regulation 9 (person centred care) and Regulation 17 (good governance). The overall rating was 'requires improvement.'
At the next inspection in June 2017, we found the provider remained in breach of Regulation 17 (good governance) and was in breach of Regulation 14 (meeting nutritional and hydration needs), Regulation 18 (staffing) and Regulation 19 (fit and proper persons). The overall rating was 'requires improvement' with the well led domain rated 'inadequate.'
Following that inspection we issued warning notices in relation to Regulations 14 and 17 and requirement notices for the other breaches. We met with the provider and they submitted an action plan showing how they planned to bring about the required improvements. The registered manager who had been in post in June 2017 left just after our inspection and a new registered manager was appointed.

During this inspection, we found the provider had made some improvements in particular around supporting people with their nutritional needs. However, we also identified a number of concerns, some of which were continued from the previous inspection. This demonstrated the provider's systems for monitoring the quality and safety of the services provided were not being operated effectively.

We found there were not enough staff deployed to meet people's needs in a timely way, which meant the provider remained in breach of Regulation 18. This had led to working practices, which were not in the best interests of people who used the service. This included getting people up and dressed from 5am without any evidence to show it was either in their best interests or in line with their needs and preferences. The provider's governance systems had not identified this and it was only dealt with when we brought it to their attention by the inspection process.

When we visited the home for a second day (4 January 2018), we saw notes from a staff meeting that had taken place on 20 December 2017. This was the day after our first visit. The meeting notes showed the registered manager had instructed staff as follows; 'With immediate effect I would like anyone who is immobile but is wet at 5am to be dressed in their day clothes but left to rest in bed.' We raised this with the provider and registered manager during feedback from our inspection. We were concerned this was an instruction to night staff to continue getting people up but to leave them on their beds so that they would not be seen downstairs. The provider and registered manager told us there had been a misunderstanding and the notes were not an accurate record of the meeting. However, the provider's quality monitoring systems had not identified this and it was only dealt with when it was raised by the inspection team.

During our inspection, we identified other concerns which resulted in breaches of Regulation and which the provider had not identified and dealt through their governance and risk management systems. For example, we found fire exits that were obstructed which meant the checks on the fire safety systems had not been done in line with the provider's schedule.

We found that although there were various audits in place they were not effective. On 19 December 2017, we identified two mattresses that had a strong smell of stale urine. The audit record showed they had been checked on 14 November 2017 and did not have an offensive odour. When we checked them again on 4 January 2018 the housekeeper told us the mattresses had been replaced. However, we found they had already started to develop an unpleasant odour again. We discussed this with the registered manager; we suggested it was either a problem with the cleaning of the mattresses, the management of people's continence needs or a combination of both. When we visited on 24 January 2018 we found improvements had been made to the management of unpleasant odours and the registered manager told us they had arranged for people's continence needs to be reassessed. However, we were concerned this had not been addressed until it was brought to the attention of the provider and registered manager through the inspection process. This showed the provider's quality monitoring systems were not effective.

We found the provider had not acted on feedback from previous CQC inspections to bring about improvements to the service. For example, during the inspection in June 2017 we made the provider aware of the importance of having information about people's Lasting Power of Attorney. During this inspection, we found similar issues with consent forms being signed by relatives who did not have the legal authority to do so.

Similarly, during the June 2017 inspection we told the provider some of the information given to people in the complaints procedure was not correct. During this inspection, we found the complaints procedure contained inaccurate information about CQC's role.

During this inspection, we found accurate and up to date records of people's care and treatment were not in place. We had raised this with the provider during our last inspection in June 2017. Although the provider was taking action, we were concerned the pace of progress was too slow and this was putting people at risk of receiving unsafe or inappropriate care. In their action plan dated 12 December 2017 the provider told us 22 out of 48 care plans had been transferred to the new format.

This was a continued breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One person living at the home told us, "Overall, It is better than some places. I have an en-suite bathroom." Relatives we spoke with said they would recommend the home to others. A visitor said, "Yes they do have relatives meetings but not many relatives visit. It used to be run down. The home has improved a lot in the last six months. Food wise, medical wise and entertainment; they get well looked after." Another visitor said, I would recommend the home to people. Overall, I am quite happy with everything."

The registered manager showed us the results of a residents/relative survey carried out in August 2017. Eleven people had responded but it was not clear from the report whether the responses had come from people who lived at the home or their relatives. The registered manager had put an action plan in place to address the areas where people felt the service could be improved.

Staff told us they felt supported by the new registered manager. They said they had seen improvements in the service since the registered manager had taken up their post.

The registered manager told us they were working closely with external agencies such as the CCG (Clinical Commissioning Group) to bring about improvements to the service.

The CQC rating was displayed in the home as required by law.