Review of compliance

Ilkley Health Care Limited Riverview Nursing Home	
Region:	Yorkshire & Humberside
Location address:	Stourton Road Ilkley West Yorkshire LS29 9BG
Type of service:	Care home service with nursing
Date of Publication:	July 2012
Overview of the service:	The home provides personal and nursing care for up to 60 older people who are living with dementia. It is a large converted property and is located close to the town centre of Ilkley. The accommodation is on four floors and consists of shared and single rooms of which 17 have en-suite facilities. There are two passenger lifts giving access to all areas. Most of the communal rooms are on the ground floor, there is one

	lounge on the first floor. There are gardens which are accessible to people.

Summary of our findings
for the essential standards of quality and safety

Our current overall judgement

Riverview Nursing Home was not meeting one or more essential standards. We have taken enforcement action against the provider to protect the safety and welfare of people who use services.

The summary below describes why we carried out this review, what we found and any action required.

Why we carried out this review

We carried out this review to check whether Riverview Nursing Home had taken action in relation to:

Outcome 10 - Safety and suitability of premises
Outcome 21 - Records

How we carried out this review

We reviewed all the information we hold about this provider, carried out a visit on 8 May 2012, looked at records of people who use services and talked to staff.

What people told us

We used different methods to help us understand the experiences of people using the service, because the people using the service had complex needs which meant that they were not able to tell us their experiences.

We observed people using the service whilst we looked around the whole home and saw that whilst some had remained in their rooms, most people were sitting in the lounges. There were televisions on in both of the lounges and we saw some activities in the downstairs lounge including dominoes and a game with a soft ball. The people using the service looked to be enjoying the activities.

Although many of the people using the service could not communicate with us, one person told us "It's alright here."

What we found about the standards we reviewed and how well Riverview Nursing Home was meeting them

Outcome 04: People should get safe and appropriate care that meets their needs and supports their rights

Peoples' needs were not assessed and care and treatment was not planned and delivered

in line with individual care plans. Care and treatment was not planned and delivered in a way that ensured peoples' safety and welfare.

The registered care provider was not meeting this standard. We judged that this had a moderate impact on people who used the service and action was needed for this essential standard.

Outcome 10: People should be cared for in safe and accessible surroundings that support their health and welfare

People who use the service, staff and visitors are protected against the risks of unsafe or unsuitable premises as the provider is working to improve the environment through a systematic refurbishment programme.

The registered care provider was meeting this standard.

Outcome 21: People's personal records, including medical records, should be accurate and kept safe and confidential

People were not protected from the risks of unsafe or inappropriate care and treatment as the documentation we saw was uncoordinated, inconsistent and contradictory.

The registered care provider was not meeting this standard.We judged that this had a major impact on people who used the service and action was needed for this essential standard.

Where areas of non-compliance have been identified during inspection they are being followed up and we will report on any action when it is complete.

Actions we have asked the service to take

We have asked the provider to send us a report within 14 days of them receiving this report, setting out the action they will take. We will check to make sure that this action has been taken.

We have taken enforcement action against Ilkley Health Care Limited.

Where we have concerns we have a range of enforcement powers we can use to protect the safety and welfare of people who use this service. When we propose to take enforcement action, our decision is open to challenge by a registered person through a variety of internal and external appeal processes. We will publish a further report on any action we have taken.

Other information

Please see previous reports for more information about previous reviews.

What we found for each essential standard of quality and safety we reviewed

The following pages detail our findings and our regulatory judgement for each essential standard and outcome that we reviewed, linked to specific regulated activities where appropriate.

We will have reached one of the following judgements for each essential standard.

Compliant means that people who use services are experiencing the outcomes relating to the essential standard.

Where we judge that a provider is non-compliant with a standard, we make a judgement about whether the impact on people who use the service (or others) is minor, moderate or major:

A minor impact means that people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

A moderate impact means that people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

A major impact means that people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly.

Where we identify compliance, no further action is taken. Where we have concerns, the most appropriate action is taken to ensure that the necessary changes are made.

More information about each of the outcomes can be found in the *Guidance about compliance: Essential standards of quality and safety*

Outcome 04:
Care and welfare of people who use services

What the outcome says

This is what people who use services should expect. People who use services: * Experience effective, safe and appropriate care, treatment and support that meets their needs and protects their rights.

What we found

Our judgement

The provider is non-compliant with Outcome 04: Care and welfare of people who use services. We have judged that this has a moderate impact on people who use the service.

Our findings

What people who use the service experienced and told us
We used different methods to help us understand the experiences of people using the service, because the people using the service had complex needs which meant that they were not able to tell us their experiences.

We observed people using the service whilst we looked around the whole home, we saw that most of them were in the lounges. People were clean and dressed appropriately.

In the lounge upstairs we saw that it was quiet and people were sat around the edge of the room, a television was on but no other activities were observed. We saw limited interaction from staff with these people using the service during our tour, although there were individuals' diet and fluid monitoring forms in the room and these had been completed.

The second larger lounge was downstairs and there were more things happening, we observed a carer playing dominoes with a person using the service and he told us "I enjoy dominoes as it is something I can still do." We also saw another member of staff playing ball with a number of people using the service. There was a television on in the corner and we saw drinks being served and people being supported with their drinks.

Another person told us "It's alright here."

Other evidence
Peoples' needs were not assessed and care and treatment was not planned and

delivered in line with individual care plans.

When we arrived on site we were told the manager was on a training course, we asked to see the person in charge explaining we were inspectors from the Care Quality Commission. There was a nurse at the medicine trolley, we asked who was in charge and we were told that it must be the trainee manager. We asked the nurse who the nurse in charge was and they said there were two nurses on duty and when we asked which of them was in charge of the home they said it must be them. There was clearly no designated clinical leader at the time of our visit.

In order to follow up actions regarding records from the inspection in February 2012, we looked at the records of four people using the service, whom we had selected randomly from people we saw during our tour. These were found to lack coherence. For example, we saw that some of the assessments and care plans were blank and the daily records were not in the individuals' files. We asked the nurse in charge about daily records and they told us that the nurses kept their daily records in a separate file and there was a separate file where the care assistants kept their daily records. The daily records were not organised into individuals' records and we found blank sheets that had been poorly photocopied which meant that the continuation of the records was disjointed. The records were also kept in various places within the home which made it difficult to bring together all the records for an individual.

Having information about peoples' care and treatment in three separate folders, kept in three different places in the home and poorly recorded made it difficult to get a clear and accurate picture of an individuals' care and treatment needs and the actions being taken to meet those needs.

Care and treatment was not planned and delivered in a way that ensured peoples' safety and welfare.

Whilst looking at some of the rooms we noted a malodour in one room which the trainee manager could not account for. On closer inspection we found that the persons' duvet cover was damp with urine and yet the bed had been made up ready for the individual to sleep in. The provider promptly had this rectified but we have not been able to test that this compliance has been sustained.

In response to our findings, we looked at other care records of people using the service rather than the random sample we had intended to review. These records were found to be incomplete with daily records kept separately from the individuals care record and assessments. The records showed that some relevant assessments had not been completed and therefore, care plans had not been put in place.

We looked at incidents documented in the accident book and found a case where a person using the service had sustained an injury but medical support/advice had not been sought. The accident book stated that an individual had fallen resulting in massive bruising to their hip. The nurses daily notes documented the incident and indicated that the bruising should be observed however, there was no entry on the body chart which was found to be blank. We asked the nurse about this and they told us that the bruising had now gone.

We asked the nursing staff to explain another incident identified in the accident book,

where we had found from their records that no action had been taken following a fall from bed. One of the nurses said they had made recommendations verbally to reduce the risk of harm to this person but these recommendations had not been recorded or acted on.

Our judgement
Peoples' needs were not assessed and care and treatment was not planned and delivered in line with individual care plans. Care and treatment was not planned and delivered in a way that ensured peoples' safety and welfare.

The registered care provider was not meeting this standard. We judged that this had a moderate impact on people who used the service and action was needed for this essential standard.

Outcome 10:
Safety and suitability of premises

What the outcome says

This is what people should expect. People who use services and people who work in or visit the premises: * Are in safe, accessible surroundings that promote their wellbeing.

What we found

Our judgement

The provider is compliant with Outcome 10: Safety and suitability of premises

Our findings

What people who use the service experienced and told us
We used different methods to help us understand the experiences of people using the service, because the people using the service had complex needs which meant that they were not able to tell us their experiences. We found that the premises were secure and provided adequate protection of peoples' rights to privacy, dignity and choice.

Other evidence
The provider was taking appropriate actions to address a compliance action following an inspection in February 2012. People who use the service, staff and visitors were protected against the risks of unsafe or unsuitable premises.

We completed a full tour of the home including a review of the refurbishment work which was underway when we visited. The whole fourth floor was unoccupied and extensive works were being completed. However, the progress of the work had been delayed by requirements to repair the roof following flooding. The very wet weather during the few weeks prior to our visit had slowed progress even further. Despite this it was apparent that work had progressed since the visit in February 2012 but not as much as expected.

We were accompanied by the trainee manager on our tour of the premises and they told us about the plans to address each of the concerns we raised from the inspection in February 2012. This was not however supported by a documented plan or strategy for the management of these major works. The operations manager agreed to forward a plan to us following the visit and this was done.

During the tour of the premises, which included the majority of the rooms, we saw that some rooms were shared but contained personal affects which gave each persons

space an individual feel. Old furniture was being replaced with new and a full refurbishment was underway on the top floor but these rooms were vacant.

The trainee manager explained to us that one person using the service was having to use the toilet facilities in an unoccupied room at night as the bathroom on that floor was out of order at the time of our visit. The persons route to these facilities was clearly marked and a night light had been situated appropriately to ensure the person could see their way safely.

However, we also saw that some routine maintenance was not being done. For example, in one room the ceiling tile directly over one of the beds was damaged and cracked, any loose matter would have fallen directly onto the persons' bed. We saw that the top step on one of the stairways was loose and could have caused someone to lose their footing and fall down the stairs. These concerns were addressed during the visit but we have not been able to test that this compliance has been sustained.

We also identified a number of minor concerns about the electrics in the lounges of the first floor and ground floor. The operations manager made the appropriate adjustments as requested to reduce the risk to the people using the service. This included removing one of the heaters from the wall and fixing trailing wires of extension leads and the TV whilst we were there but we have not been able to test that this compliance has been sustained. Arrangements were made for new electrical sockets and a new radiator to be installed the next day and following the visit the provider confirmed that this had been done.

Our judgement
People who use the service, staff and visitors are protected against the risks of unsafe or unsuitable premises as the provider is working to improve the environment through a systematic refurbishment programme.

The registered care provider was meeting this standard.

Outcome 21:
Records

What the outcome says

This is what people who use services should expect. People who use services can be confident that: * Their personal records including medical records are accurate, fit for purpose, held securely and remain confidential. * Other records required to be kept to protect their safety and well being are maintained and held securely where required.

What we found

Our judgement

The provider is non-compliant with Outcome 21: Records. We have judged that this has a major impact on people who use the service.

Our findings

What people who use the service experienced and told us
We used different methods to help us understand the experiences of people using the service based on the records being fit for purpose because the people using the service had complex needs which meant that they were not able to tell us their experiences.

We found that contradictory information within a care plan for one person using the service had resulted in another person using the service being harmed.

Other evidence
Peoples' personal records were inaccurate and not fit for purpose. The individuals' records were kept securely but could not be located promptly as they were stored in a number of different places.

We looked at the records of four people using the service in order to check that the compliance action, set following the review of compliance in February 2012, had been addressed. Each person's records had been put into separate sections within a large folder using numbered divider sheets, however there was no indexing system in place and therefore information was difficult to find.

We saw that some of the assessments and care plans were blank. The daily records were not in the individuals files we saw. We asked the nurse in charge and she told us that the nurses kept their daily records in a separate file and there was a separate file where the care assistants kept their daily records. Having information about people's care and treatment in three separate folders, kept in three different places in the home made it difficult to get a clear and accurate picture of people's care and treatment needs

and the actions being taken to meet those needs.

We looked at the care records of one person using the service as we had observed extensive bruising to the person's face and we wanted to see if the person had received appropriate care. The daily records were non specific about the bruising therefore we had to look at the accident book to find information. This showed that the chaotic nature of the records and the lack of a documented system to convey information between staff shifts had resulted in a number of actions not being communicated or acted upon.

This prompted us to review other care records. These records were also found to be incomplete with daily records kept separately from the individuals care record. We reviewed the content of the care record for another person using the service and found evidence of contradictory information regarding the care to be delivered.

The absence of clearly documented information about the persons' needs and the actions that should be taken to meet those needs meant that the person was at risk of not receiving appropriate care and treatment and other people using the service were at risk from their behaviour not being managed correctly.

We saw a separate overarching list of peoples' weights which revealed that one person using the service had lost a significant amount of weight in a three month period. When we looked further we saw that the documentation for monitoring nutritional intake for that individual was incomplete and that although the staff had noted the refusal of meals no action was planned or taken to address this.

The lack of ongoing review and care planning seen during the visit demonstrated risk of people using the service not receiving safe and appropriate care.

Our judgement
People were not protected from the risks of unsafe or inappropriate care and treatment as the documentation we saw was uncoordinated, inconsistent and contradictory.

The registered care provider was not meeting this standard.We judged that this had a major impact on people who used the service and action was needed for this essential standard.

Where areas of non-compliance have been identified during inspection they are being followed up and we will report on any action when it is complete.

Action
we have asked the provider to take

Compliance actions

The table below shows the essential standards of quality and safety that **are not being met**. Action must be taken to achieve compliance.

Regulated activity	Regulation	Outcome
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 04: Care and welfare of people who use services
	How the regulation is not being met: Peoples' needs were not assessed and care and treatment was not planned and delivered in line with individual care plans. Care and treatment was not planned and delivered in a way that ensured peoples' safety and welfare.	

The provider must send CQC a report that says what action they are going to take to achieve compliance with these essential standards.

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's report should be sent to us within 14 days of the date that the final review of compliance report is sent to them.

Where a provider has already sent us a report about any of the above compliance actions, they do not need to include them in any new report sent to us after this review of compliance.

CQC should be informed in writing when these compliance actions are complete.

Enforcement action we have taken

The table below shows enforcement action we have taken because the service provider is not meeting the essential standards of quality and safety shown below. Where the action is a Warning Notice, a timescale for compliance will also be shown.

Enforcement action taken			
Warning notice This action has been taken in relation to:			
Regulated activity	**Regulation or section of the Act**	**Outcome**	
Accommodation for persons who require nursing or personal care	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 21: Records	
	How the regulation or section is not being met:	**Registered manager:**	**To be met by:**
	People were not protected from the risks of unsafe or inappropriate care and treatment as the documentation we saw was uncoordinated, inconsistent and contradictory.		07 June 2012
Regulated activity	**Regulation or section of the Act**	**Outcome**	
Diagnostic and screening procedures	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 21: Records	
	How the regulation or section is not being met:	**Registered manager:**	**To be met by:**
	People were not protected from the risks of unsafe or inappropriate care and treatment as the documentation we saw was uncoordinated, inconsistent and contradictory.		07 June 2012
Regulated activity	**Regulation or section of the Act**	**Outcome**	

Treatment of disease, disorder or injury	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 21: Records	
	How the regulation or section is not being met:	**Registered manager:**	**To be met by:**
	People were not protected from the risks of unsafe or inappropriate care and treatment as the documentation we saw was uncoordinated, inconsistent and contradictory.		07 June 2012

What is a review of compliance?

By law, providers of certain adult social care and health care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The Care Quality Commission (CQC) has written guidance about what people who use services should experience when providers are meeting essential standards, called *Guidance about compliance: Essential standards of quality and safety*.

CQC licenses services if they meet essential standards and will constantly monitor whether they continue to do so. We formally review services when we receive information that is of concern and as a result decide we need to check whether a service is still meeting one or more of the essential standards. We also formally review them at least every two years to check whether a service is meeting all of the essential standards in each of their locations. Our reviews include checking all available information and intelligence we hold about a provider. We may seek further information by contacting people who use services, public representative groups and organisations such as other regulators. We may also ask for further information from the provider and carry out a visit with direct observations of care.

Where we judge that providers are not meeting essential standards, we may set compliance actions or take enforcement action:

Compliance actions: These are actions a provider must take so that they **achieve** compliance with the essential standards. We ask them to send us a report that says what they will do to make sure they comply. We monitor the implementation of action plans in these reports and, if necessary, take further action to make sure that essential standards are met.

Enforcement action: These are actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers are set out in the law and mean that we can take swift, targeted action where services are failing people.

Information for the reader

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