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:	August 2012
Overview of the service:	The home provides personal and nursing care for up to 60 older people. 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 areas 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 meeting all the essential standards of quality and safety inspected.

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 04 - Care and welfare of people who use services
Outcome 21 - Records

How we carried out this review

We reviewed all the information we hold about this provider, carried out a visit on 2 August 2012, observed how people were being cared for, looked at records of people who use services, talked to staff and talked to people who use services.

What people told us

We spoke with five people who were using the service and they all told us they were happy with the care they were receiving at Riverview Nursing Home.

One person told us that "They look after me really well. I have no complaints about the care I have received". and another person told us "They are good to me here" and another that "I wouldn't be able to go home regularly for visits now if it weren't for the good care I get 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

People experienced care, treatment and support that met their needs and protected their rights.

The registered provider was meeting this standard.

Outcome 21: People's personal records, including medical records, should be

accurate and kept safe and confidential

People were protected from the risk of unsafe or inappropriate care and treatment.

The registered provider was meeting this standard.

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 compliant with Outcome 04: Care and welfare of people who use services

Our findings

What people who use the service experienced and told us
During our inspection we were able to talk with five people using the service but many of the people using the service had complex needs which meant that they were not able to tell us their experiences so we observed how staff interacted with people living at Riverview Nursing Home.

Of the five people we spoke with, one person told us "They look after me really well. I have no complaints about the care I have received".

Another person told us "They are good to me here" and another said that "I wouldn't be able to go home regularly for visits, if it weren't for the good care I get here".

Other evidence
Our inspection of 08 May 2012 found that care and treatment was not planned and delivered in a way that ensured peoples' safety and welfare. As a result there was a reasonably foreseeable risk that peoples' needs may not be fully met. The provider wrote to us and told us that they would improve the systems for the management review of care planning and delivery; ensure related staff attended safeguarding up-date training and review the documentation used in the home by the end of July 2012.

We have reviewed these elements and found that the provider had completed these actions

Care and treatment was planned and delivered in a way that ensured peoples' safety

and welfare.

During our visit we saw care being given and watched staff interacting with the people using the service. We saw that the staff were speaking to the people in a pleasant manner and using appropriate language to ensure that people knew what was happening to them.

All the people we saw in the lounge were clean and dressed appropriately and were being engaged in appropriate activities which were supported by a newly appointed activity coordinator.

We looked at five sets of care records for people using the service. They demonstrated clear assessment of needs for all of the five people whose records we saw. The risk assessments were relevant to each individual and included assessments of personal care, mobility, falls, nutrition, hydration needs and religious and cultural needs. The risk assessments being used were noted to be based on recognised methods of assessment.

We also saw that where the risk assessments had identified a risk new care plans for each specific problem were in place. This provided staff with the information they needed to protect people from the risks.

The care plans also recognised religious and language needs, hobbies and interests and end of life care decisions. We saw that all five of the records had signed consent by the person using the service or their representative for the planned care.

Other information seen within the care records included a falls diary, weight charts and information which related to a persons' capacity to make decisions for themselves.

We saw that the service was monitoring food and fluid taken by people who had difficulties eating and weights were being monitored and reviewed regularly. Concerns were being discussed with appropriate health professionals where required.

Our judgement
People experienced care, treatment and support that met their needs and protected their rights.

The registered 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 compliant with Outcome 21: Records

Our findings

What people who use the service experienced and told us
We spoke to people using the service but their feedback did not relate to this standard.

Other evidence
Our inspection of 08 May 2012 found that people were not protected from the risks of unsafe or inappropriate care and treatment as the documentation we saw was uncoordinated, inconsistent and contradictory. As a result there was a reasonably foreseeable risk that peoples' needs may not be fully met. The provider wrote to us and told us that they would improve the records including the reporting of incidents, assessments and care plans and improve the management systems for review of the documentation by the end of June 2012.

We have reviewed these elements and found that the provider had completed these actions.

People were protected from the risks of unsafe or inappropriate care and treatment.

The home is now being managed as two separate units with staff allocated to be in charge of each unit although there is an option for the units to support each other if required. The care records are kept in a locked cupboard within each unit ensuring that the care records are kept close to that unit.

We looked at five sets of care records for people using the service, including people from both units. We saw that the records had changed since our last visit in May 2012 and they demonstrated clear assessment of needs for all of the five people whose records we saw. The risk assessments were relevant to each individual and included assessments of personal care, mobility and falls, nutrition, hydration needs and religious and cultural needs. The risk assessments being used were noted to be based on recognised methods of assessment.

We also saw new care plans which were specific to each problem that had been identified through the assessments. These included personal care, mobility, transfers, continence, appetite and nutrition, sleep, dementia, mental capacity, the environment, medication and emotional care plans. The care plans also recognised religious and language needs, hobbies, interests and end of life care decisions. We saw that all five of the records had signed consent by the person using the service or their representative for the planned care.

Other information seen within the care records included a falls diary, weight charts and legal information in particular where it related to a persons' capacity to make decisions for themselves. Significant events were clearly recorded and showed that the home was including relevant other health professionals at appropriate times.

We spoke with four members of staff regarding the changes in the care records. The care coordinator and nurse explained that they had been involved in the compilation of the new records but that the decisions about what was required in the new documentation had been agreed by the team of nurses. They also told us that they felt the new format of the records was a real improvement which was benefitting the people using the service as the care plans were now clear. The three staff that we spoke with also told us that they felt that they were clearer about the needs of the people using the service and that the allocation to the units had made things better.

The Registered Manager told us that the care records had been checked every week when they were initially introduced but that was now less frequent as the records were being updated regularly by the staff.

We also looked at how the staff were reporting and acting upon accidents and incidents. The accident book was looked at and we found it was appropriately completed. The Registered Manager told us that they were reviewing the accident book regularly. An incident file had been developed which included guidance notes on actions to be taken following certain types of incidents with relevant contact information and blank incident forms.

The provider had established communication books for both the nurses and the carers which meant that outstanding actions were clearly identified and acted upon.

Our judgement
People were protected from the risk of unsafe or inappropriate care and treatment.

The registered provider was meeting this standard.

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

Document purpose	Review of compliance report
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