Mrs Rishpal Singh

Riverview Residential Home

Inspection report

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Ratings

Overall rating for this service	Inadequate
Is the service safe?	Inadequate
Is the service well-led?	Inadequate

Overall summary

We carried out an unannounced comprehensive inspection of this service on 11 February 2015. During that inspection we found that the service was not always safe because guidance was not always available for staff on how people should receive medicines that should be administered on an 'as required bases. We also found that the service was not always effective because people's dietary supplements were not always managed appropriately.

We undertook this follow-up inspection to check if improvements had been made following the previous inspection of the service. After last inspection we received concerns in relation to staff training and skills, fire safety and over-all management of the service. As a result of these, we also focused on these areas of concern. This report only covers our findings in relation to these concerns and areas of concern from the last inspection. However, we did not assess the effective question during this inspection because no one who used the service required dietary supplements and therefore there were no dietary supplements at the service. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for (location's name) on our website at www.cqc.org.uk.

We inspected Riverview on 4 January 2016 and the inspection was unannounced. The service is registered to provide accommodation and personal care to a maximum of eight people. They are not registered to provide nursing care. At the time of our inspection, eight people used the service.

Summary of findings

Staff did not always recognise abuse and/or take appropriate action when abuse was suspected. People did not always have risk assessments or risk management plans in place to guide staff on how they should receive care. People's risk assessments and management plans were not updated when their needs changed.

We found that people's medicines were not always managed safely. This meant that people were at risk of receiving inappropriate doses of medicines that did not meet their needs and they did not always have their medicines when they needed them.

People were at risk of harm because they did not always have the skills to provide people the care they required. People had not been trained effectively on how to support people with their mobility safely.

The provider did not always notify us (the CQC) of events and incidents that had occurred in the service, of which they were required to notify us about.

The provider did not have effective systems in place to regularly monitor the quality of service provided. People's care records did not always reflect the care they required or received.

We identified that the provider was not meeting some of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 we inspect against and improvements were required. You can see what action we are taking at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not safe.

Staff did not recognise abuse and take appropriate action when abuse was suspected. People did not always have risk assessments and management plans to ensure their safety when care was being provided. People's medicines were not always managed safely.

Inadequate

Is the service well-led?
The service was not well-led.

The provider did not always notify us of events and incidents that occurred at the service. The provider did not have effective systems in place to ensure that staff received appropriate training in order to carry out their roles effectively. Concerns were not always responded to effectively. Care records did not always reflect the care people received or required. The manager did not have effective systems in place to regularly assess and monitor the quality of services provided.

Inadequate

Riverview Residential Home

Detailed findings

Background to this inspection

We undertook an unannounced focused inspection of Riverview Residential Home 4 January 2016. This inspection was completed to check that improvements had been made following our last inspection of the service on 11 February 2015. We also followed up on concerns that had been raised about the service after the inspection. We inspected the service against two of the five questions we ask about services: is the service safe; and is the service well- led? This is because improvements were required in these areas. We did not inspect the service against the question: is the service effective? This was because, although they required improvement for this question following the last inspection, nobody who used the service during this inspection was appropriate to be reviewed for the areas we were concerned about.

This inspection was undertaken by one inspector. During this inspection, we spoke with seven people who used the service, two relatives of people who used the service, two professionals who visited the service, two staff members and the manager. We observed how general care was provided to check if staff ensured that people's safety was maintained effectively.

We reviewed the information we held about the service. Providers are required to notify the Care Quality Commission about events and incidents that occur including unexpected deaths, injuries to people receiving care and safeguarding matters. We refer to these as notifications. We reviewed the notifications the provider had sent us and additional information we had requested from the local authority safeguarding team and commissioning team.

We looked at three people's care records to help us identify if people received planned care and we reviewed records relating to the management of the service. These included training records, recruitment records, accident and incident records, complaints records and maintenance records. These records helped us understand how the manager responded and acted on issues relating to the care and welfare of people, and how the manager monitored the quality of the service.

Inadequate

Is the service safe?

Our findings

The provider did not always recognise and take appropriate action when abuse was suspected. A relative of one person who used the service expressed concerns to us that they felt their relative who used the service was at risk of abuse. We asked care assistant information about this and they said, "From my point of view, I don't understand what [one of the friends] is trying to do to [person who used the service]. They [the friend] speak nicely to [person who used the service] in front of us but when we are not there, they start raising their voice to [person who used the service]. We've been before and told them [friend] to put their voice down". The care assistant told us they also suspected the person was being financially abuse by their friends.

We asked the manager if they were aware of these concerns and they said, "Yes they [friend of person who used the service] shouts at [name of person who used the service]; and I think this person is taking money off [person who used the service] but I'm not sure and don't want to get involved". Both staff and the manager had not recognised that what they had described was potential abuse and it was their responsibility to report this to the local authority to be investigated. We reported this as a safeguarding to the local authority after the inspection. The manager had not taken appropriate action when abuse was suspected.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 Regulations 2014.

We observed two care assistants trying to assist one person from their chair on to a wheel chair. The person could not weight- bare and the two care assistants were struggling to help the person out of their chair. The person almost fell out of their chair whilst they were being assisted into a wheel chair held by the care assistants. We had to ask the care assistants to stop the procedure as this was not safe. This person had just returned from surgery following a fall at the home. The deputy manager intervened and asked for a standing aid to be brought, which was then used to help the person to transfer from their chair on to the wheelchair. We checked the person's care records and noted that the person's risk assessments and management plans had not been updated following the fall and the person's return from hospital. The deputy manager told us that they were awaiting a physiotherapy assessment for the person however, there were not care plans in place for how the mobility needs will be managed. This person had been at risk of harm because there were no risk assessments and management plans in place to guide staff on how to support the person with their mobility.

This person also told us they were in constant pain and we observed this. They said, "I wish I was a lot better. I get a lot of pain. That seems to bother me more than anything else. I don't want to make a fuss but I want to be understood. It's a horrible sort of pain. It's like a tooth ache". The person told us they had medicines during the usual medicine times and when they told staff they were in pain. We observed person complaining about pain for most of the morning but did not ask staff for pain relief. There were periods during the day when the person appeared to be confused. We checked the person's care records to see if there was a plan in place for how their pain would be monitored and managed post-surgery but there were no care and management plans in place for this. This meant that staff did not have clear guidance on how to ensure the person remained pain free, post-surgery.

We reviewed the person's medicines administrations records (MAR) to check if the person received regular pain relief. MAR records showed that the person had been prescribed two different types of pain killers to be given on 'as required' basis but there was no guidance for staff on how this should be done. Records showed that for over six days since being discharged from hospital post-surgery back to the home, the person was being given one type of pain killer. We observed that the manager gave the person the two different pain killers at once during the afternoon medicines round. We asked the manager why this had been done and they said the district nurse had advised them that afternoon that this could be done. However, this advice was not recorded on the MAR or in the person's care records to guide other staff who may have to administer the medicine in the absence of the manager. We observed later that the person fell fast asleep and appeared to be pain free shortly after having taken the medicines. The manager commented that the combination of painkillers must have taken effect. This showed that the person had not been receiving the appropriate amount of pain killers to keep them pain-free. We raised a safeguarding referral for this because the person was at risk of neglect.

We noted that two people's medication administration records had been wrongly transcribed by the manager from

Inadequate

Is the service safe?

the medicine boxes on to their MAR. We pointed out the transcription errors to the manager who was dispensing the medicines at the time and they corrected this with their pen. They told us the hospital had not provided a summary of the person's medicines so they copied what had been written on the medicine boxes, on to a MAR chart for the person. We informed them it was their responsibility to ensure that people had appropriate medicines administration records with them prior to being discharged from the hospital to the home.

During the medicine administration round we noted that the manager signed that two people had received their medicines before the medicines had been administered to these people. MAR should only be signed when staff are certain that people have taken their medicines. People were at risk of harm because there was the potential for their MAR to indicate that they had received prescribed medicines when they may not have taken them.

The concerns above indicate a breach of Regulation 12 of the Health and Social Care Act 2008 Regulations 2014.

Inadequate

Is the service well-led?

Our findings

The deputy manager told us one person had recently fallen at the service and was taken to hospital. It was later discover that the person had fractured their hip and required surgery. However, the manager had not notified us of this event. Providers are required by law to notify us about events and incidents that occur including unexpected deaths, serious injuries to people receiving care and safeguarding matters. We refer to these as notifications.

When we reviewed the manager's accident and incident records we found that another person who used the service had fallen down a flight of stairs and had to be taken to hospital by the emergency services for a check-up. The person's care records stated that, "[Person's name] fell down the stairs and was found in a semi-foetal position upside down at the bottom of the stairs between the wall and the stairs". The person was taken to hospital by emergency services and sustained minor bruises. The provider moved the person to a room downstairs to minimise the risk of them falling down the stairs again. Providers are required by law to notify us of any injuries that require treatment by another healthcare professional in order to prevent harm to the person who used the service. The provider had not notified us of this event.

The concerns above indicated that the manager was a breach of CQC (Registration) Regulation 18, Regulations 2009.

We saw that people's care records did not always reflect the care they received or how their care should be provided. For example, We observed that staff had used a standing aid to help one a person transfer from their sit on to a wheel chair but records did not indicate this was the appropriate equipment to be used to assist the person with their mobility.

We checked the care records of two people who were on respite care and found that they did not have any care plans in place or risk assessments and management plans. The deputy manager told us "We do not put them on the system until they are permanent". The deputy manager told us they used assessments carried out by the social worker prior to the person beginning to use the service and did not do their own risk assessments and management plans until if the person became a permanent resident. The person who had fallen and sustained an injury was admitted for respite care

The manager did not have effective systems in place to assess and monitor quality because, audits had not identified and acted on the fact that people on respite care did not have care plans and risks assessments. MAR record audits had not identified that some MAR charts had been wrongly transcribed.

The provider did not have effective systems in place to regularly assess the quality of their training in order to ensure that staff remained competent and supported to carry out their roles effectively. We observed two staff members supporting one person with their mobility and noted that the techniques they used were unsafe. We saw that the person had been at risk of falling. We checked the provider's staff training records to see if the staff involved that had received training on safe moving and handle of people. The provider's training records showed that all staff had received the training. The deputy manager told us that the training consisted of watching a DVD and doing a short assessment. There were not practical assessments to ensure that staff had practical knowledge of what they had just learnt from the DVDs. The manager confirmed this and told us it was expensive to get an external trainer to come on site to provide training for a small number of staff but planned for the deputy manager to go on a manual handling trainer's course so that they could in turn provide manual handling training at the service. Other than the initial training given to staff on medicine administration, there were no systems in place to regularly assess the competency of staff who administered medicines.

One of the relatives we spoke with told us they had raised several concerns about the care of their relative to the manager but did not feel like the manager had made satisfactory efforts to deal with the concerns. They told us that they did not feel that staff as well as the manager made significant effort to encourage their relative to attend to their personal hygiene although they had raised these concerns several times. Staff we spoke with and the manager confirmed that the relative had raised these concerns on several occasions but these had not been recorded and responded to as appropriate. The staff member and manager told us that they often asked the person to attend to their personal hygiene but the person

Inadequate

Is the service well-led?

usually declined and they had to respect the person's choices because the person had capacity to make decisions. However, there were no records to show that the concerns of the relative had been dealt with effectively.

The concerns indicated a breach of Regulation 17 of the Health and Social Care Act 2008 Regulations 2014

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Care and treatment was not always provided in a safe way because people did not always have appropriate risk assessments and management plans in place. People's medicines were not always managed appropriately.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment The provider did not recognise and/or take appropriate action when abuse was suspected.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider did not always ensure that records relating to the care and treatment of people who used the service were accurate, up-to-date and consistent. The provider did not have effective systems in place to regularly assess, monitor and improve the quality and safety of the services provided the.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents The provider did not always notify the CQC of incident which occur at the service, of which they were required to notify us about.