Mrs C Day and Mr & Mrs S Jenkins

Riverside Court

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Riverside Court is a residential care home providing accommodation and personal care to up to 25 people. The service provides support to older people and people living with dementia. Riverside Court supports people across 3 floors, with various communal spaces including pleasant outdoor areas. At the time of our inspection there were 22 people using the service.

People's experience of using this service and what we found
The service was not safe. Risks to people were not appropriately assessed, monitored, and managed. Daily notes were not always robust. The security of the building had not been reviewed to ensure people and staff remained safe. Some health and safety checks were out of date. Actions to address unsafe water temperatures and fire safety had not been fully addressed. Infection prevention and control was not safely managed. Medicines were not always stored securely, and medicine records were not always completed. Safeguarding concerns were not consistently raised or investigated in a timely manner, and relevant organisations were not routinely notified. Staff absences were not always covered and not all staff had received up to date key training.

Systems were not in place to adequately assess, monitor, and improve the quality and safety of the service. There were no formal provider audits, and audits completed by the registered manager had not identified most of the issues found on inspection. The quality of the service had deteriorated since our last inspection. Systems had not identified that incidents were not always appropriately reported. People, relatives, and staff were not always fully engaged in the running of the service.

Some areas of people's care plans were person-centred. Staff knew people well. People felt safe and settled and spoke positively about the staff. The registered manager was very responsive following our feedback and took action to mitigate risks identified. A schedule of provider audits was implemented following the inspection. Most relatives, people who used the service, and staff, spoke positively about the leadership of the registered manager. The service was consistently described as friendly, welcoming, and homely. Relatives told us communication was good, and they were kept up to date.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was good (published 8 January 2021).

Why we inspected

We received concerns in relation to safeguarding and a potential closed culture. As a result, we undertook a focused inspection to review the key questions of safe and well-led only. For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

The overall rating for the service has changed from good to inadequate based on the findings of this inspection.

We have found evidence that the provider needs to make improvements. You can see what action we have asked the provider to take at the end of this full report.

The provider has responded immediately following our feedback to mitigate the risks identified.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Riverside Court on our website at www.cqc.org.uk.

Enforcement
We have identified breaches in relation to safe care and treatment, safeguarding, staffing and good governance at this inspection.

Please see the action we have told the provider to take at the end of this report.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures.' This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the 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.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Riverside Court

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
This inspection was carried out by 2 inspectors.

Service and service type
Riverside Court is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Riverside Court is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager in post.

Notice of inspection
This inspection was unannounced.

Inspection activity started on 7 September 2023 and ended on 3 October 2023. We visited the service on 7, 12 and 28 September 2023.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with 10 people who used the service and 7 relatives about their experience of the care provided. We spoke with 9 members of staff including the registered manager, senior care workers, care workers and a cook. We spoke with 1 of the business partners.

We reviewed a range of records. This included 8 people's care records and multiple medication records. We looked at 2 staff files in relation to recruitment. A variety of records relating to the management of the service, including training data and quality assurance records were reviewed.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

- People were at risk of harm. Risks to people were not appropriately assessed, monitored and managed. People's records were not always clear or up to date. Key risks to people had not always been robustly considered, such as the risk of self-harm and the risk of access to the stairs. There were significant gaps in reposition charts, for people who were unable to turn themselves and were at risk of skin breakdown.
- The building was not secure. All staff and relatives were provided with a key code which meant they could access the building at any time of the day or night. The key code had not recently been changed which meant that former staff members and former relatives were still able to access the building.
- Actions identified during a fire risk assessment in July 2022 had not been fully addressed. The basement area of the building was cluttered and had not been divided into compartments to help prevent the risk of fire. There was no evidence that staff had completed fire drills. One staff member told us, "I have had online fire training, but I have not completed any fire drills."
- Some health and safety checks were out of date, including the annual gas safety check. Where water temperature checks had highlighted that water temperatures in people's rooms were too high, there was no evidence of any actions taken and the issue was not resolved. This placed people at risk of scald injuries.

Risk was not effectively assessed, monitored, and managed. This placed people at risk of harm. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The registered manager was responsive to our feedback and started to address the issues raised.
- Staff knew people well and people told us they felt well supported. One person told us, "We don't want for anything." One relative told us, "I cannot praise them enough; they care for [person's] every need."

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 MCA 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 to receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

- We found the service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty. Any conditions related to DoLS

authorisations were being met.

Preventing and controlling infection
● Infection prevention and control (IPC) was not safely managed. The laundry room and the basement area were dirty in places and unhygienic. The laundry practices did not support good infection control.
● PPE and clinical waste were not disposed of appropriately or safely. Staff who were assisting at mealtimes had not all received food safety training.
● The provider's IPC policy was not up to date or tailored to the needs and practices of the service.

Infection prevention and control was not managed safely. This placed people at risk of harm. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People's rooms and the communal areas were clean and personalised.
● Family members were able to visit their relatives whenever they wished.

We have signposted the provider to resources to develop their approach.

Using medicines safely
● Medicines were not managed safely. The records did not evidence people received their topical creams as prescribed. Care plans around the administration of creams were unclear, and there were multiple gaps in the daily cream records.
● Medicines were not stored safely. A controlled drug was not stored or administered in line with legal requirements. Some prescription medicines were not locked away and were potentially accessible to people who used the service, and who might not understand the risks posed by the medicines.
● Medicine administration records did not always contain key information such as people's allergies and some medicines that were prescribed on a 'when required' basis. Handwritten changes to medicine administration records were not checked or countersigned and verbal changes made by the GP were not followed up in writing.

Medicines were not always managed safely. This placed people at risk of harm. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● During the inspection, the service transitioned to an electronic system to manage the medicines and creams. This system would enable the registered manager to have greater oversight of medicines.
● People were appropriately supported to self-administer their own medicines where possible.

Systems and processes to safeguard people from the risk of abuse; learning lessons when things go wrong
● Systems and processes to safeguard people from the risk of abuse were not robust.
● Safeguarding concerns were not always raised or investigated in a timely manner. Staff did not always feel confident or comfortable raising concerns, and this placed people at risk of harm.
● Safeguarding referrals and notifications were not always submitted, which meant the service was not fully engaged with local safeguarding systems.
● Safeguarding and learning from incidents were not always given priority or included as topics in staff meetings and supervisions. Not all staff had received up to date training in safeguarding.

Systems and processes to safeguard people from the risk of abuse were not always robust. This placed people at risk of harm. This was a breach of regulation 13(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The registered manager was responsive to our feedback and took immediate action to engage with local safeguarding teams and to improve staff understanding and knowledge in this area.
● People told us they felt safe. Comments included, "Carers work their socks off for us, they're fantastic", "[Staff] have a lovely sense of humour" and, "I love it here. The staff are so good, they are so caring and considerate." One relative told us, "[Person] is settled and safe; we are very pleased."

Staffing and recruitment
● There were not always sufficient numbers of suitable staff to support people's needs. There was no evidence that robust systems were in place to calculate safe staffing levels and to regularly review those levels.
● Staff absences were not always covered. One person told us, "If somebody phones in ill, it causes chaos." We were not assured that when staffing levels were reduced, these remained safe. One staff member told us, "If there is the slightest issue then we can be very short staffed very quickly. The provider doesn't like to use agency staff, but at times staffing can be dangerously low."
● Some people fed back about finding there were not enough staff on duty at night. Comments included, "I press the call button, and nothing happens at night" and, "Nighttime feels like a low ration. If there was a crisis, [staff] would be struggling."
● There was no activities co-ordinator at the time of the inspection. This was being addressed, however, we observed limited stimulation for people throughout the inspection.
● Staff were missing some key areas of training such as safeguarding for kitchen and domestic staff, and fire drills for all staff.

There were not always enough suitable staff to support people's needs. This placed people at risk of harm. This was a breach of regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The registered manager was working extremely hard to cover shifts wherever possible. New staff had recently been recruited.
● Staff were recruited safely, with appropriate pre-employment checks in place.

Inadequate

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; continuous learning and improving care

- Systems were not in place to adequately assess, monitor, and improve the quality and safety of the service. This placed people at significant risk of harm. The systems in place had not identified the shortfalls with IPC, fire safety, security of the building, risk assessments and general risk management, staffing, and safeguarding.
- There was no evidence of formal audits or checks carried out by the provider, although we were told the provider attended the service regularly and was in regular contact with the registered manger.
- Audits completed by the registered manager had not identified most of the concerns we identified on inspection. The registered manager was new to the manager role and received no formal supervisions from the provider.
- Regulatory requirements were not always complied with. Services that provide health and social care are required to inform CQC of important events which happen in the service by submitting a 'notification'. During inspection we found the provider had failed to submit several notifications. The registered manager submitted these retrospectively.

Systems had not been established to effectively assess, monitor, and mitigate risks to the health, safety and welfare of people using the service. Systems had not been established to effectively monitor and improve the quality of the service and to ensure accurate, complete and contemporaneous records were in place. This was a breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The provider was responsive following our feedback. The provider implemented a schedule of formal audits with a view to increasing oversight and ensuring that governance systems would enable issues to be identified and resolved in a timely manner.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; how the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- Systems and procedures had not identified the inconsistent reporting of risks and incidents.
- The provider had not created an environment whereby staff fully understood their safeguarding responsibilities and felt confident and comfortable to raise concerns in a timely manner, with all appropriate parties, when things went wrong.

Systems and procedures had not identified the inconsistent reporting of risks and incidents. This was a breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Most relatives, people who used the service, and staff, spoke positively about the leadership of the registered manager. Relatives told us, "[The registered manager], especially with the workload she has, is doing a sterling job. She handles things admirably" and, "[The registered manager] is excellent and we are very lucky to have her." Staff told us, "[The registered manager] is the best and nicest manager we have had."
● The service was consistently described as friendly, welcoming, and homely. One staff member told us, "It is like a little community, and we all work as a team."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; working in partnership with others
● People, relatives, and staff were not always fully engaged in the running of the service. There was no evidence of meaningful discussions with people, relatives, staff, and professionals, about the running of the service, with a view to supporting continual improvement.
● There were no formal and meaningful opportunities for people and relatives to provide feedback about the service, with a view to evaluating and improving the service. There were no formal residents' or relatives' meetings.
● There were no formal questionnaires or surveys used, apart from an electronic survey which appeared when visitors signed out of the building. Results from this electronic survey were not meaningfully explored and analysed.

There was a failure to seek and act on feedback. This was a breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Relatives told us communication was good, and they were kept up to date. One relative told us, "[Staff] get in touch with me straight away if they need to."
● The registered manager ensured there was an open-door policy, and people consistently told us they could speak with the registered manager when needed, and she was responsive. One relative told us, "[The registered manager] is really good, I can talk about issues with her, and we sit down together and make a plan."
● There was a weekly ward round carried out by a GP. Staff made referrals to healthcare professionals when needed. One relative told us, "When [person] has needed hospital, that has been done straight away, and the [registered] manager came in from home to sit with [person]."

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

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 failed to have robust systems and processes in place to safeguard people from abuse. Regulation 13(1), (2) and (3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed to ensure there were always enough suitable staff to support people's needs. Regulation 18(1) and (2)(a)

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations 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 The provider failed to effectively assess, monitor, and manage risk. The provider failed to ensure the safety and security of the building. The provider failed to safely manage infection prevention and control. The provider failed to manage medicines safely. Regulation 12(1) and (2)(a), (b), (d), (g) and (h)

The enforcement action we took:

Warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to have systems in place to effectively assess, monitor, and mitigate risks to the health, safety and welfare of people using the service. The provider failed to maintain securely an accurate, complete, and contemporaneous record in respect of each service user. The provider failed to have systems in place to effectively monitor and improve the quality of the service. The provider failed to have systems in place to ensure appropriate and timely notification of risks and incidents.

The provider failed to seek and act on meaningful feedback.

Regulation 17(1) and (2)(a), (b), (c), (e) and (f)

The enforcement action we took:

Warning notice