Mrs C Day and Mr & Mrs S Jenkins

Riverside Court

Inspection report

Bridge Street, Boroughbridge, YO51 9LA
Tel: 01423 322935
Website:
www.riversidecourtresidentialcarehome.co.uk

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Ratings

Overall rating for this service	Requires improvement
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?	Requires improvement

Overall summary

This inspection was unannounced and took place on 29 May 2015. The last inspection took place in April 2014 and was a routine inspection; we had no concerns following that inspection. The service was meeting the regulations.

Riverside Court is registered to provide personal care and accommodation for up to 25 older people; some people are living with dementia. The home is located in the market town of Boroughbridge where there is a wide range of shops. The building which is over three floors is a former hotel, which overlooks the River Ure. The service has been undergoing renovation over the last three years, and is working towards all bedrooms being en suite. At the time of our inspection there were 19 people living there and another person was there on a short break.

The service did not have a registered manager. At the time of our inspection we were aware the manager had applied to the Care Quality Commission to become the registered manager, the application is in progress. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like

Summary of findings

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.

At this inspection we found the service was in breach of four regulations. Safe care and treatment of people who used the service which related to the safety of the environment, poor risk assessments and concerns regarding the safe management of medicines; person centred care, consent to care and how the service monitored quality of care and provision. You can see what action we told the provider to take at the back of the full version of the report.

There were areas of the environment that were not safe. A room was being refurbished and a wall had been knocked down. This room had not been locked so people who used the service could access it and were at risk of injury. There were wires trailing on a corridor which posed a trip hazard. Not all of the stair cases had handrails, and a member of staff told us they were concerned people who used the service could fall and hurt themselves. There were no risk management plans in place regarding people's safety on the stairs.

Medicines were not safely managed.

The safeguarding policy was out of date and staff could not confidently talk to us about how to protect vulnerable adults from the risk of harm. We have made a recommendation about safeguarding adults.

Accidents and incidents were not reviewed so lessons were not learnt to reduce risks to people in the future.

There were however, sufficient numbers of staff to provide people with the care and support they needed and evidence that staff had been recruited safely.

The principles of the Mental Capacity Act were not being followed. Staff were not aware of this legislation, or why it was important when supporting people who were living with dementia. Staff had not received training regarding this. We saw evidence of mandatory training in other areas, but very few people had been trained to support people living with dementia.

Staff received regular supervision and annual appraisals. They told us they felt well supported, and had regular staff meetings. However, care staff did not have all of the relevant training required, particularly in relation to supporting people living with dementia. We have made a recommendation about training.

People told us the food was good. We saw lunch was a calm and pleasant experience for people and people were supported to have a nutritious diet.

Overall, people received adequate care and support. However, we saw one person with more complex needs did not receive the support they needed.

People told us care staff were kind and caring. Care staff gave us examples of how they supported people in a dignified and respectful way.

Care planning was not always up to date and this meant people may not receive the appropriate care and support.

There was limited meaningful stimulation and activity for people.

The manager was not able to provide us with all of the information we requested during the inspection. The service did not have effective audits in place to monitor or assess the quality of care people received. Policies were out of date.

We were unable to review complaints made to the service as the manager could not provide this information.

People and their relatives had the opportunity to give feedback on the service through an annual survey and regular meetings with the manager.

Staff told us they felt well supported by the management team and enjoyed working at the service.

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?

Inadequate

The service was not safe.

The environment posed some risks to people.

Medicines were not managed safely.

Risk assessments were not always completed. Accidents and incidents were not reviewed so there was nothing learnt about them. We were unable to review the accidents and incidents recorded as the manager could not find the book.

Staff did not have up to date knowledge about how to safeguard people. The policy was out of date. Staff did not know about whistleblowing.

There were sufficient staff available to meet people's needs. Staff were recruited safely.

Is the service effective?

Requires improvement

The service was not consistently effective.

The principles of the Mental Capacity Act were not being followed by staff. The manager and care staff had minimal knowledge of the legislation and what this meant for people living with dementia.

Staff had not received all of the training they required to give them the skills they needed to support people.

Supervision and appraisals took place, and staff told us they felt well supported.

People told us they enjoyed the food. The lunchtime experience was calm and well organised. Where people needed adapted cutlery to support their independence this was provided.

Is the service caring?

Requires improvement

The service was not consistently caring.

Staff were not always aware of people's discomfort and took action without consulting people about their preferences.

Staff ensured people's privacy and dignity were respected.

Relatives were encouraged to visit and made to feel welcome.

People did not have access to information about advocacy services.

Is the service responsive?

Requires improvement

The service was not consistently responsive.

Summary of findings

We saw staff did not provide the support one person required, they were unwell. We asked the manager to arrange a visit by the person's doctor.

Care plans and risk assessments were not always up to date. This meant people may not be getting care and support they required.

There was limited stimulation and activity for people.

We were unable to review complaints as the manager could not provide this information.

Is the service well-led?

Requires improvement

The service was not consistently well-led.

The manager was not able to provide the inspection team with all of the information we required.

Audits were not taking place on a regular basis, and the medicines audit was not effective. Policies were out of date.

The care and support provided was not based on up to date practice. Although the manager had recently visited a service to get some ideas about how to make improvements for people living with dementia.

People and their relatives had the opportunity to give feedback on the service at regular meetings and via the annual survey. Staff told us they felt well supported and enjoyed working at the service.

Riverside Court

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 was planned to check 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 took place on 29 May 2015 and was unannounced.

The inspection team consisted of two inspectors, a specialist professional advisor (who was a nurse with experience of working with older people and in dementia care) and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert by experience on this visit had experience with older people and people living with dementia.

Before our inspection we reviewed all the information we held about the service. We had received a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We contacted Healthwatch, which is an independent consumer champion that gathers and represents the views of the public about health and social care services in England; they did not have any feedback to share regarding the inspection. We asked the local authority commissioners whether they had any feedback; they told us they had not had any concerns raised regarding the service.

During the inspection we spoke with eight people who used the service, three relatives, and six members of staff which included one of the owners who is also the manager, three care workers, the cleaner and chef. We also spoke to two visiting health professionals. We observed the medications round and care being provided in the communal areas of the home. We looked in people's bedrooms, and communal bathrooms. We also observed lunch and tea.

We looked at documents and records that related to people's care, and the management of the home such as training records, policies and procedures. We looked at six care plan records and four staff files.

Inadequate

Is the service safe?

Our findings

All of the people we spoke to who used the service told us they felt safe. One person said, "Oh aye, it's safe enough here" another said, "Safe? Yes, as far as I know." Despite this we had some concerns about the safety of people who used the service.

We were concerned about the safety of the environment for people who used the service. On the first floor there was a bedroom that was being refurbished. We walked into the room and found half of the wall had been knocked down. The manager was with us and told us they were extending the room to make it big enough for an en suite bathroom. There was rubble and plaster on the floor. Although no one was living in the room, it was not secured and people who used the service had access to it. This meant people were at risk of injury if they entered the room.

We raised this concern with the manager immediately. They agreed the door should have been secured to protect people. Whilst we were there a lock was fitted to secure the door. We saw work was on going throughout the inspection. We checked during the inspection and found the door was secured when the work man was not working in it.

On the same floor we found wires trailing from one room into another. The wires were in the middle of the corridor and posed a trip hazard for people who used the service, visitors and people who worked there.

We asked care staff whether they thought people who lived at the service were safe. One member of staff commented on the staircases. They told us they were worried someone could fall and injure themselves. There were two floors above the ground floor and a staircase at each end of the building. These were not secured so people could access them independently. The main stair cases had hand rails. However, in some places there were half stair cases between landings where there were no handrails. We told the manager we were concerned people could be at risk of falling and injuring themselves. We asked what risk assessment and management plans were in place. The manager told us there were no risk assessments in place but they felt people could manage the stairs independently, and those that could not would not try without help from staff.

We wrote to the manager following the inspection to request they completed risk assessments regarding people's use of the stairs. They confirmed these had been put in place following our inspection.

We found some areas of concern regarding medication management within the service. These were in relation to administration, recording and management of medicines.

We observed the medication round and saw one person being given tablets that had been tipped into the member of care staff's palm, and then given to the person from a spoon. This posed an infection risk. The member of care staff, administering the medication, told us their last medication training was three years ago. This meant their training was out of date, and they were not aware of current good practice.

We checked 20 medication administration records (MAR). We saw one person was left with their medication and care staff then recorded, 'F' on the MAR chart. We asked the member of staff what 'F' meant as this was not one of the codes on the MAR chart. We were told this code meant the person was left with their medication and took it after the member of care staff had left. This had not been recorded clearly and therefore meant care staff could not be clear about whether the medication had been taken.

We looked at medicines stored in the medication trolley. We saw three boxes of Paracetamol were not labelled by the supplying pharmacy. Instead, they had hand written names on them and were stored in the door of the medicine cabinet. One box which had been prescribed for one person had another person's name written on the label. This meant medication was being shared by people who used the service which does not follow good practice guidance. We found both people had previously been prescribed Paracetamol. One person had a hand written note at the front of their medication records which stated that they had been seen by the doctor, and the Paracetamol had been discontinued. Co-codamol was prescribed as an alternative. This record was not dated or signed so we could not see when this change had taken place.

We saw a box of Paracetamol which contained out of date tablets. The pharmacy label was dated 25 April 2012. We asked the senior carer what the process was for disposal of unused or out of date medicines. They explained these

were registered in a book and passed to the chemist who disposed of them. The member of care staff could not tell us why the out of date medication was still be in the medication cupboard.

PRN medication was recorded on separate sheets. We saw for two people the records were on the back of the printed sheet. The senior carer told us the printed sheets they were supposed to fill in had run out and the assistant manager was on holiday so they had not replaced them.

The manager told us accidents and incidents were recorded in a book. However, they were unable to locate this during the inspection. We asked how they would know if someone had hurt themselves or had an accident. The manager said, "We're only very small so I would know."

We asked the manager for a copy of the personal emergency evacuation plans for people using the service. They were not able to locate the folder in a timely manner. This was of concern as they should be easily accessible for the emergency services. One located, the plans were in date and there was one for each person who used the service.

The service was not protecting people from receiving unsafe care and treatment, or working to prevent avoidable harm. This was a breach of Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2014.

The service's whistleblowing policy was last updated in 2003, however, they had downloaded a CQC information document on whistleblowing, this was on the noticeboard in the office. But when we asked care staff about their understanding of whistleblowing, they were unable to tell us what this was. When we explained what it meant one member of care staff then replied, "Oh, grassing on staff." They were unable to tell us who they would contact if they had concerns about the service, which were not dealt with by the manager.

Care staff showed a limited understanding of how to protect vulnerable adults from avoidable harm. They were unable to tell us how to detect the signs of abuse, and needed prompting to tell us about the types of abuse. Care staff did say they would tell the manager if they were worried about someone. The safeguarding policy was out of date; it was from 2003. Therefore, it did not take into account recent changes to legislation, policy or practice. We looked at staff training for safeguarding adults, whilst the majority of staff had received training in the last 12 months we saw two staff had not received training since 2012, and four staff since 2013.This meant staff were not aware of updated safeguarding practice, and could mean people who used the service were not protected from avoidable harm.

Since the last inspection CQC have been notified about one safeguarding incident. We reviewed this as part of this inspection and found this had been managed well by the service despite the fact that existing guidance and processes were in need of review. This had been dealt with by the manager's assistant and we could see the appropriate referrals had been made. The person concerned had a detailed risk assessment and management plan in place to manage the issues identified.

We recommend the provider review their policies, procedures and guidance for staff regarding safeguarding adults.

During our inspection we observed that there were sufficient staff on duty to meet people's needs. People who used the service told us they did not have any concerns about staff and were responded to quickly. We looked at the rota for the last four weeks and saw that the numbers of staff on duty during our inspection were consistent over that period. The manager told us they had a stable staff team, and never used agency staff.

We looked at four staff files and found appropriate checks had been undertaken before staff began work. These included checks through the Disclosure and Barring Service (DBS). The DBS checks assist employers in making safer recruitment decisions by checking prospective staff members are not barred from working with vulnerable people.

People who used the service told us it was always clean. We found the communal areas; bathrooms and people's bedrooms were clean and free from odour.

Requires improvement

Is the service effective?

Our findings

The Mental Capacity Act (MCA) 2005 provides a legal framework for acting and making decisions on behalf of people who lack the ability to make specific decisions for themselves. The Care Quality Commission monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. These safeguards are in place to protect the rights of people who use services, by ensuring if there are any restrictions to their freedom and liberty, these have been authorised by the local authority as being required to protect people from harm.

We spoke to the manager about their understanding of the MCA. They told us these assessments were completed by their assistant, who was the only member of staff who had completed any training in relation to the legislation.

We asked two members of care staff to tell us about their understanding of the MCA. They were unable to explain what this legislation was or why it would be important for people who lacked the mental capacity to make their own decisions

In the six care plans we looked at we found mental capacity assessments were completed, but they were variable in content and quality. We found one person was assessed as being able to make their own decisions. However, they had some behaviour which challenged the service. We saw they had a door sensor to alert staff when they had left their room. There were clear risk assessments to show this had been set up to manage the identified risk the person presented to themselves and others. The service had applied for a DoLS for this person. This would have been unnecessary if the person had the capacity to make their own decision regarding the door sensor. This meant they had been assessed incorrectly or the current legislation was not being appropriately applied.

The service had applied for DoLS for one person. The documentation for the urgent authorisation, which lasts for seven days, had been submitted. This was out of date and we could not see the standard authorisation paperwork. The manager told us it had been applied for but they were unable to produce this documentation. This meant the service had not assured themselves people were not being deprived of their liberty unlawfully.

The manager and care staff were not aware of the principles of the Mental Capacity Act and DoLS legislation. They were not assessing people's ability to make specific decisions. In addition to this there was no record of best interest decisions. A best interest decision is a decision made on behalf of a person who is unable to make their own decision and should involve the person's family or friends and other health and social care professionals. This meant the service was not following the principles of the Mental Capacity Act 2005 when planning peoples care. They were not applying the DoLS effectively as they were not aware of recent policy updates regarding this. This was a breach of Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2014.

We found conflicting evidence about the training care staff had received. The manager could not find the training matrix which would have shown a list of who had attended what training and when. We looked at a sample of training records in staff files and an on line record which the manager showed us.The on line record was not up to date. However, we saw evidence in training files of training certificates which had not been added to the online record. Therefore, we asked the manager to send a copy of the training matrix after the inspection.

We received this and reviewed the information. We found the majority of staff had received training about nutrition, fire safety, health and safety, infection control and safeguarding adults. However, only four out of 20 staff listed had undertaken training in dementia awareness. When we asked one member of care staff about dementia training they said they didn't think it was necessary as, "It's all common sense really." We asked another member of care staff if they felt they understood different aspects of dementia and how to provide support to people with dementia, they said, "Not really but I do [feel confident] because I've done it for so long."

We were unable to see any evidence that the manager had completed any training to support them in their role.

We recommend the provider review staff training to ensure care staff have the sufficient skills and knowledge to support the people they care for.

We looked at supervision records for three members of care staff and confirmed this took place on a regular basis. Supervision is an opportunity for staff to discuss any training and development needs, any concerns they have about the people they support, and for their manager to

Requires improvement

Is the service effective?

give feedback on their practice. The records were detailed and had been signed by both the supervisor and supervisee. We also saw that staff had received an annual appraisal.

There was no evidence of any specific adaptations to create a dementia friendly environment. There were no signs apart from usual signs for bathrooms and toilets. Some people had names and pictures on their bedroom doors to help them recognise their room.

People who used the service told us they enjoyed the food. Comments included, "It is nice", "The food is pretty good" and, "The food varies a little bit, depends on what you like. It is hot enough, they cover it up, and there is enough to eat." A visiting relative told us, "The food is nice."

We saw the chef asking people what they wanted for lunch, there was a choice of fish and chips or ham salad. We spoke to the chef who told us people had the choice of two main meals, but if people preferred something else they would always make what they fancied. They gave us examples of a bacon sandwich or cheese on toast. They told us they asked people what kind of food they liked, and explained that cakes were baked for people's birthdays and there was a roast dinner each Sunday. They told us no one had any specific dietary needs, but if people were not well they would blend or puree food.

The tables in the dining room were nicely laid with tablecloths, cutlery, glasses and small flower decorations. Twelve people ate their lunch in the dining room. Overall it was calm and well organised and we heard people having conversations whilst eating. Music was playing in the background and people were not rushed. However, we noticed two people had to wait 15 minutes after everyone else for their main course.

We saw one person had adapted cutlery to help them eat independently. There appeared to be no choice of drinks, everyone was offered orange juice. Everyone in the dining room had fish & chips and people told us it was nice. One person said, "'It's nice, the fish & chips, nice and flaky." People ate most of their food, and were offered tinned fruit and cream for dessert.

Only one person in the dining room needed support to eat their meal. We saw a member of care staff supported the person to be independent. They assisted them by cutting up their food and putting a spoon in their hand. However, the person ate very slowly and appeared to be struggling to keep awake. This person could have benefitted from adapted cutlery and/or a plate guard as they found it difficult to manage.

At tea time we observed tea being served to people in the dining room. The food was presented well and care staff encouraged people to eat. There was a choice of ploughman's with bread and butter or poached egg on toast. There were also individual home baked cakes. However, tea was poured from a pot already mixed with milk, this meant there was no choice for people in how strong or weak they preferred their tea to be served. This was evidence of institutionalised practice and should be reviewed.

Overall, people had access to a nutritional diet, they told us they enjoyed the food and were able to make choices. We saw people's weight was being checked on a regular basis. We saw one person had lost weight, however we were told they were unwell. Overall, we saw no evidence of significant weight loss in people who used the service.

Requires improvement

Is the service caring?

Our findings

The manager told us the service was small, family run and was caring. They said the small size of the service meant they knew people well. People who used the service told us staff were kind. One person said, "They're great. I've no problems with them." Another person told us, "They've been all right to me. She's a nice person." They were referring to a member of care staff who walked past.

Although people told us staff were caring, we observed some areas of concern. In the morning, the temperature in the lounge felt cool to the inspection team. One person who lived at the service was shivering, and told us they were cold. We found a member of care staff and they brought additional clothing and a rug. Another person said, "It's been getting a bit cool now." Staff did not notice this situation, check with people whether they were OK or take any other action until prompted by inspectors. An hour later, the service felt as though it had warmed up. However, later in the morning, a member of care staff came into the lounge and said, "Ooh, it's very warm today. Let's open a window, get some fresh air." The member of care staff did not ask the people who used the service whether the temperature was right for them. This meant care staff were not always taking into account the needs of the people who used the service or asking them about their preferences.

We heard someone in their room asking for help. They told the cleaner, "I want to go to the toilet but no-one will help." The cleaner spoke kindly to the person and said, "One moment, I'll help." They then went to fetch a member of care staff. We asked the cleaner what they thought was good about the home. They said, "The care, and the warmth of the staff."

We saw a member of care staff reassuring someone who felt unwell, they were asking the person how they felt, they replied, "I don't know. I just don't feel right." The member of care staff used a gentle tone, and said, "It's not your fault." The member of care staff sat with the person for a while and checked on them throughout the afternoon.

We observed care staff knew people well. They addressed people by their name and were kind in their manner. We also heard care staff referred to people by the words 'darling' and 'sweetheart', people did not seem to be offended by this. They made eye contact with people and got on a level with them when talking to people. We saw members of care staff gave encouragement and reassurance to people. One person who was using a Zimmer frame and was given reassurance by staff, they said, "Take your time."

Everyone we spoke to told us visitors were welcome at any time. One person who lived at the service said, "Yes, they can visit at any time." Another person told us, "Visitors come all the time." A visiting relative confirmed this, and said they were welcome to visit at any time.

Staff told us they treated people with dignity and respect. A member of care staff explained how they always ensured people were 'covered up' when they were being supported with intimate personal care. They said they maintained people's privacy, and explained, "I wash their top half and cover them up, if I need to go and get a cloth, I explain what I'm doing."

The manager told us no one needed support from advocacy. However, we did not see any information about advocacy services on display. The service should ensure this information is accessible for people who use the service.

Requires improvement

Is the service responsive?

Our findings

All of the people who lived at the home on a permanent basis had a detailed pre admission assessment. This meant the service was assessing people to ensure they could meet their needs before they moved in. The manager told us they carried out these assessments, and were happy to say no to people if they did not feel they could offer them the care they needed.

One person was there on a short break. There was detailed information in the form of an email, which had been provided by the person's family. The service had completed a 'new client assessment' form, prior to them coming to stay at the service. There was a record of the person's previous medical history, a list of their current medication, and emergency contact details which included their doctor. However, none of this information had been used to create a care plan for staff to follow. This meant the person's preferences were not recorded and there were no instructions for staff about the level of care and support the person needed. We spoke to the manager about this and we were told this had been missed, as a result of their assistant being on leave. We suggested this needed to be completed as a priority and the manager agreed.

We saw one person who used the service looked unwell. They spent the morning asleep on their own in the side lounge. They were sat in a reclining chair with their feet up, and had a pressure relieving cushion and a blanket. The person was in the same position in the reclining chair from 9.30 am until 12.30. We did not see care staff check on the person or assist with personal care or a drink, or reposition them in the chair.

We asked the manager and care staff about this person and we were told they had been deteriorating over the last few days. The manager told us they thought the person was approaching the end of their life due to advanced dementia. We asked when they were last seen by a doctor, and were told 14 May 2015. They confirmed a doctor had not been consulted about their recent deterioration.

We looked at the person's care plan; we saw a review had taken place on 7 January 2015. Since this time we did not see any evidence of updated care planning or risk assessments in relation to this person's deteriorating health. There was no evidence of end of life care planning. This meant the care plan and associated risk assessments did not reflect the person's current needs.

The person did not receive any care from 9.20 am until lunchtime. At 12.30 pm a member of care staff came and woke the person up, they tried to assist them to eat some mashed up fish and chips. The person did not seem to be awake enough to eat. Twenty minutes later another member of care staff returned and was more successful in rousing the person, however, instead of trying again with the food they assisted the person to eat yoghurt. The yoghurt was 0% fat. This was not an adequate source of nutrition for the person.

The person weighed 38 kg and had lost weight on three consecutive months. There was a note to say the GP was aware of this, however, we could not see a record of any advice or guidance they had provided.

Later in the day we were speaking to the chef. A member of care staff came to ask the chef, "We are pureeing all [person's name] food now aren't we?" The chef said, "Yes, if it's needed." The member of care staff replied, "It's just that the family are asking." The member of care staff did not know the answer to this even though they had been caring for the person, and the care plan did not say food should be pureed. This meant care staff were unclear about the support this person needed to ensure they were having adequate nutrition and were hydrated. If a pureed diet was assessed as being necessary and the person was not receiving this they might be at risk of choking.

We could not see a food or fluid chart or a repositioning chart in place for this person. We checked with the manager, and they confirmed they were not recording this. We were concerned the person may be at risk of developing pressure ulcers.

The service did not have the necessary risk assessments or up to date care plans to enable care staff to be clear about the care and support this person needed. This meant the person was at risk of receiving inadequate care. We spoke to the manager about our concerns for this person's health and wellbeing and they agreed to request an urgent visit by the doctor. We also shared our concerns with the local authority safeguarding team.

This was a breach of regulation 9 HSCA 2008 (Regulated Activities) Regulations 2014.

Requires improvement

Is the service responsive?

We looked at five other care plans. They recorded people's preferences and life experiences before they had moved into the service. This was recorded on a document called, 'Life Journey.'

The 'life journey' information was detailed in the care plans we looked at but there was limited evidence about how this information was being used to inform care plans, particularly in relation to social activities.

We saw detailed risk assessments and management plans in place for one person and could see their family and the relevant health and social care professionals had been involved in developing these. However, these were not up to date in all of the care plans we looked at. This meant people could be at risk of not receiving the care or treatment they needed to support them to be safe and well.

The manager told us care plans were reviewed every three months or sooner if the person's needs changed. Reviews were completed in some cases, and some who used the service told us they were involved, however, the documentation was not always signed by the person undertaking the review.

During our inspection we noted the call bell noise was extremely loud. We asked the manager whether people were able to use call bells to request help and they told us this varied due to their dementia. We asked the manager whether they had recorded this anywhere or taken steps to minimise the risk of people being unsafe if they were unable to call for assistance and we were told they had not. The manager told us they wanted to install a new system which would enable them to monitor the length of time it took staff to respond to call bells, however, there was a disagreement between them and the other partner, and therefore this had not been approved.

We had been told on the provider information return the service had received one complaint since the last inspection. However, when we looked in the complaints file we could not see this. Unfortunately the manager was unable to locate the information for us and therefore, we could not review whether this had been resolved. We did not see a copy of the complaints policy in communal areas of the home. It was not readily available for people who used the service or their families.

We received mixed feedback from people about the activities available to them. Comments included, "I'm not terribly impressed with bingo," "I sleep and watch TV. I like racing and sport," and, "People do things, I do. I keep up with paperwork, the newsletter Daily Chat. They do all sorts of things. I go out. It's quite an interesting place really."

However, we saw minimal activity throughout the inspection. In the morning there were some older tunes playing. One person, who was listening to the music, repeatedly said "1939." They remarked that the music was from a film with Humphrey Bogart but there was no care staff around to pursue the conversation with them. People sat in the lounge area and appeared to be bored. In the afternoon we saw two people were sat at a dining room table doing a jigsaw. There was a staff member present for part of the time.

We spoke to care staff about the range of activities and stimulation for people. They told us about sing-alongs, jigsaws and music. The service is located on the river in the centre of Boroughbridge. We asked care staff whether they ever took people into the town. They told us they didn't, and gave us the impression that it was down to family members to take people out. One member of care staff said, "This place is all to do with the families, families are here all the time."

On the notice board we saw an advertisement for a private company, Companion Care. The advert explained they would support people with shopping trips or days out, 'at reasonable rates.' we were not sure why this would be offered as something people would need to pay extra for this.

We spoke to the manager about the activities available for people. They said, "We try to do something every afternoon." They told us they had an external activities person who came in twice a week, for one hour each time. They did keep fit and hand massage. The manager said they organised trips out of the home on a regular basis. We saw a list of events which were booked throughout the year, there were seven in total. The manager told us they arranged a day trip on the minibus twice a month. We saw some photographs of trips. There was a church service every month.

Care staff said the outside area, through French windows off the main lounge, was used in the summer for people to

Requires improvement

Is the service responsive?

sit outside. This area overlooked the river and was picturesque. The manager told us they were looking at making this area secure so people could access the garden unsupervised.

Overall we found the service was not responsive to people's needs. Changes to people's needs were not assessed; this meant care staff did not have up to date guidance on how to support people. This meant people who used the service were at risk of receiving care which did not meet their needs. People who used the service did not have the opportunity to engage in meaningful activity based on their choices.

Requires improvement

Is the service well-led?

Our findings

The service does not have a registered manager. The manager has applied to CQC to become the registered manager and this is in progress.

Staff meetings took place on a regular basis and staff told us they found these helpful. We saw a copy of the meeting minutes which demonstrated good attendance. We could see actions were carried forward and progress was discussed at the next meeting. At each meeting staff were given the opportunity to comment on the service.

We saw 'resident & relatives' meetings took place on a regular basis and were well attended. The minutes were detailed and showed people were given an opportunity to comment on the service.

The service also carried out an annual survey. This was sent to people who used the service, relatives and health professionals. The feedback received about the service was positive, people said access to health care and the cleanliness of the home was very good. The only negative comments were about the lack of activities and the environment, particular reference was made to patterned carpets and how difficult this makes navigating corridors and stairs for people with dementia. Comments had been collated and any required actions were recorded.

One comment read, "Overall care is high quality, but friendly and informal, an excellent combination."

The manager explained they had been to a service in Bolton which offered specialist dementia care. As a result of this visit they were planning to make the garden more secure and easier to access for people so they could go out independently. Another area they wanted to develop was dementia training for their staff and making the environment more dementia friendly.

Staff told us they felt well supported. One member of care staff said, "There are always people to talk to, it's a lovely place to work to tell you the truth, if you've got personal problems they will talk to you, they will try and help." Another said, "I just love working here, I wouldn't change it for the world, I love it."

However, whilst we found the manager was practical and caring, they did not demonstrate they had the necessary knowledge and skills to support people who used service or staff appropriately. They appeared to rely significantly on their assistant. Throughout the inspection the manager struggled to locate the relevant information we required, or answer questions about the running and management of the service. Their assistant was on holiday and they told us they would have been able to provide the information we required. This was not adequate, the manager should have been able to supply us with all of the information we requested. Of particular concern was the length of time it took them to locate the emergency evacuation plans.

We gave the manager repeated opportunity throughout the inspection to tell or show us what made their service a good one for the people who used it. They responded by saying it was a small, homely and family run service where they cared about the people they looked after. The manager told us if someone needed to attend a hospital appointment they would take them in their own car.

We asked the manager what quality assurance was undertaken by the service. The manager provided us with a quality assurance folder which contained audits. The majority of the audits we saw recorded dated back to 2014. The only audit which was up to date was a medication audit. This was being completed monthly by the manager's assistant. It recorded a check of medicines for one person. There was limited information about what had been audited, and no record of any areas for improvement or actions which were needed. We told the manager the audits were out of date and asked for any other evidence of how they assessed whether the service was delivering good care. We were not provided with any further evidence. This meant the service did not have effective systems to audit or monitor the quality of service provision The medication audit had not picked up any of the concerns the inspection highlighted in relation to medicines.

We did not see any review of accidents and incidents to see if there were any themes or patterns. It was not clear how the service learnt from accidents and incidents, to reduce the risk of reoccurrence and to protect people from harm.

The service did not have systems and processes in place to monitor and improve the quality and safety of service provision. This was a breach of Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2014.

Requires improvement

Is the service well-led?

All of the policies the service had were dated in 2013. This meant they did not take into account any changes to legislation, policy or practice. They did not contain up to date details of organisations staff could approach with any concerns.

We tried to establish what recent training the manager had attended, their view was that they ran a good service, had been a part owner in the family run business and had worked there for 26 years, and did not feel they needed to develop their skills further. This meant they had not kept up to date with changes in legislation, policy and good practice.

The manager advised us their role focused on assessing new people for the service, food ordering, a management role of any safeguarding issues and staff issues such as recruitment, payroll, disciplinary issues, and completing the staff rota. They also said a big part of their job was as 'entertainment officer.' With the role of their assistant being; staff training, medication management, liaising with doctors and other health and social care professionals, care planning and staff supervision.

We asked the manager how many people at the service were living with dementia. They gave us a list of names; as we observed people and reviewed their care plans it was evident the manager had not been able to tell us the names of all the people living with dementia.

There was no evidence of consistent good practice at this service particularly in relation to the care of people living with dementia. There was no evidence to suggest that the service was using NICE guidelines or other relevant guidance in their care of people with dementia.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The service had not completed up to date re-assessments of people's needs, despite evidence that these had changed. The service did not have the necessary risk assessments or up to date care plans to enable care staff to be clear about the care and support this person needed

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent The service had not ensured staff were aware of the relevant legislation. They were not assessing people's ability to make their own decisions. When people were unable to give consent to decisions we did not see records of Best Interest decisions.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The service was not preventing people from receiving unsafe care and treatment, or working to prevent avoidable harm.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 (2) (a) (b) (f) HSCA 2008 (Regulated Activities) Regulations 2010 Good Governance.

This section is primarily information for the provider

Action we have told the provider to take

The service was not completing effective audits to ensure they were delivering a good service or assessing and monitoring risks to people who used the service.