Care Quality Commission

Avante Care and Support Limited

Riverdale Court

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Riverdale Court is a care home providing personal care and accommodation to people aged 65 and over. Riverdale Court accommodates up to 80 people across four separate units in one building, each of which have separate adapted facilities. At the time of our inspection there were 78 people using the service.

People's experience of using this service and what we found
During this inspection, we found improvement was required in relation to some aspects of medicines management and how the service was being managed. There were systems in place to record accidents and incidents, however sufficient analysis was not in place particularly with regards to the high number of falls at the service. The current systems in place were not robust enough to assess the quality and safety of the service effectively.

The service had safeguarding procedures in place and staff had a clear understanding of these procedures. Risks to people's health and safety were assessed. Relatives told us they felt people were safe and their needs were being met. There were appropriate numbers of staff deployed to meet people's needs. Appropriate recruitment checks had taken place before staff started work. Staff followed appropriate infection control practices.

The manager and staff worked in partnership with health and social care providers to plan and deliver an effective service.

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 5 December 2019)

Why we inspected
We received concerns in relation to the management of medicines, infection control and staffing. As a result, we undertook a focused inspection to review the key questions of safe and well-led only. We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

The overall rating for the service has changed from good to requires improvement. This is based on the findings at this inspection.

You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for

Riverdale Court on our website at www.cqc.org.uk.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service.

We have identified a breach in relation to medicines management and people's safety in relation to falls 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 return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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 always safe. Details are in our safe findings below.	**Requires Improvement**
Is the service well-led? The service was not always well-led. Details are in our well-Led findings below.	**Requires Improvement**

CareQuality Commission

Riverdale 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 Care Act 2014.

Inspection team
The inspection team on site consisted of one inspector and a pharmacist inspector. After the inspection, an Expert by Experience made telephone calls to people and relatives. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Riverdale Court is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service did not have a manager registered with the Care Quality Commission, however the current manager had applied to register and this was being assessed at the time of this inspection. This means that, once registered, they and the provider will be legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all of this information to plan our inspection.

Requires Improvement

Is the service safe?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement.

This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Using medicines safely
• We could not be assured that people were receiving their medicines as prescribed.
• We found evidence people's medicines were not always given as prescribed even though Medicines Administration Records (MARs) showed they were. This meant that MARs were incorrectly completed.
• This was also not in line with the service's medicines policy which stated 'It is essential that the person that administers the medicines refer to MAR at the time of administration and does not sign MAR until after the medication has been administered and they are certain that it has been taken. A record must be made if the medicine is refused, or not administered including the reason why.'
• For example, a medicine pod was found for one person who was prescribed time sensitive medicines for Parkinson's disease which had not been administered. Records showed communications from the Parkinson's specialist nurse advising that the timing of these medicines being administered was critical to the person responding to these medicines. This advice was not being adhered to. Safeguarding records showed a similar incident had also occurred previous to this instance.
• Some medicines had been found on the floor. Records showed the medicines had been entered in the destruction register, however both the senior care worker and the manager were not aware of this until we informed them on the day of the inspection.
• We found both incidents had not been recorded as medicines incidents and had not been escalated to the senior management team in a timely manner.

Some aspects of people's medicines were not being managed safely. This is a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• The manager took prompt actions in response and relayed disappointment that these incidents had not been reported quickly enough. The manager told us they met with all the senior care leads to ensure they were remaining with each person to ensure medicine was taken before signing the MAR chart. They told us staff would also be observed to ensure this was followed correctly.
• The manager also told us that staff had been reminded that any 'found on the floor' medicines must be reported immediately to the manager.

Learning lessons when things go wrong
• The provider had a system in place to record and respond to accidents and incidents. Records showed actions taken in response including notifying relevant healthcare professionals and CQC. However, we noted

there were a number of falls occurring at the service and some relatives shared some concerns about people's mobility following falls at the service.
• A relative told us "[Person] has had a succession of falls and two weeks ago had an unwitnessed fall. They called the paramedics and they kept me informed all the time." Another relative told us "[Person] had only been there a day and fell and had to go to A&E, then 2 days later fell again and back to A&E. Finally, they gave [person] a zimmer and since been more stable."
• We enquired about the number of falls with the manager who told us a falls record was completed on a weekly basis. We noted the falls records completed between 2 May 2021 and 19 May 2021, showed there were twenty-one falls, eleven of which occurred in people's bedrooms and nine in communal areas such as the hallway and lounge areas. The falls records only provided details of the nature of the falls and actions taken in response to the incident. There was no further analysis undertaken to identify any trends and to reduce the number of falls at the service.

This is a further breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• When speaking to staff, they were aware of people's needs and actions to take if a person had a fall. A staff member told us "When people are at high risk of falls, they are referred to the falls team. Some people have crash mats and sensor mats in place to alert staff that they have fallen or that they are moving around. We carry out half hourly checks to make sure they are safe."

Systems and processes to safeguard people from the risk of abuse
• People were protected from the risk of abuse. A relative told us "I am very happy with the care. [Person] is safe and comfortable and well looked after." Another relative told us "I don't have any concerns at all about [person's] care."
• There were safeguarding adults and whistle blowing procedures in place. Staff had received training on safeguarding and were provided with information regarding who to report potential safeguarding concerns to. A staff member told us "I would report any concerns I had straight to the manager. The manager is brilliant with these things and reports to the safeguarding team. I know about our whistle blowing policy and would have no problem using it if I had to."
• The manager understood their responsibilities in relation to safeguarding and told us they would report any concerns immediately to the local authority and CQC.
• We saw a safeguarding log that included reports sent to the local authority safeguarding team and the CQC. The deputy manager confirmed there were currently three concerns being investigated by the local authority and the service.

Assessing risk, safety monitoring and management
• People's care records included risk assessments for example on falls, moving and handling, skin integrity, eating and drinking and catheter care. Risk assessments included information for staff about actions to be taken to keep people safe. Care plans and risk assessments were kept under review and updated when necessary.
• People had individual emergency evacuation plans which highlighted the level of support they required to evacuate safely.
• Health and safety checks including fire safety, lifts, mobility equipment, water temperature checks and electrical and gas safety checks were carried out to ensure the environment and equipment was safe for use.

Staffing and recruitment
• There were sufficient numbers of staff deployed to meet people's needs. The manager showed us rotas and

told us staffing levels were arranged according to people's care needs. If people's needs changed, they said they would work with the local authority to ensure that safe staff cover was in place to meet people's needs.
• The provider followed safer recruitment practices and had ensured appropriate pre-employment checks were completed satisfactorily before care workers were employed.
• Relatives told us "[Person] really likes the carers and tells me 'they are very kind here'." Another relative told us, "The staff are really kind and lovely."

Preventing and controlling infection
• The provider was taking appropriate measures to prevent people and staff catching and spreading infections. The deputy manager told us they continually sought and followed current government advice on COVID-19. The provider was accessing testing for people using the service and staff. Feedback from relatives confirmed this. A relative told us "They [staff] all wear gloves and aprons and masks and the families are tested, and everyone is 2m apart. it's very safe."
• The provider's infection prevention and control policy was up to date. Staff had received training on infection control, COVID- 19, and we observed they were using PPE safely and were abiding by shielding and social distancing rules. A staff member told us, "There is plenty of PPE. I had training on infection control, COVID-19, putting on and taking off PPE. When visitors come here, they get checked when they come in and they have to wear PPE. We always make sure we are socially distancing."
• The provider employed a housekeeper and domestic staff team. The home looked very clean throughout.

Requires Improvement

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 the last inspection this key question was rated as outstanding. At this inspection this key question has now deteriorated to requires improvement.

This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

• Audits had been conducted by the manager and the provider which covered various aspects of the service including infection control, nutrition, fire health and safety and business continuity. However, we found improvement was needed in relation to medicines, falls management and the way the service was being managed.
• Feedback from some relatives indicated some aspects of the service were not well led and required improvement. They told us communication was lacking. A relative told us, "They aren't very good at communicating. The doctor went in last week, but the home doesn't always phone to let you know what's going on." Another relative told us "They are really poor at communicating. They only phone if something is wrong so for example, they didn't phone to tell me [person] was having their second [COVID-19 vaccination] injection, simple things like that." A third relative told us "Communication is awful. We rung five times and the phone just rings or they answer it and say they are busy and to phone back."
• Some relatives told us they were not aware of who the manager was at the service. A relative told us, "I have no idea who the manager is." Another relative told us, "I know the name of the manager, but I have no idea what they are like, I think I have only ever had email/letter from them." A third relative told us, "I don't know who the manager is, I deal with [staff members] who are the care leaders."

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
• The home did not have a registered manager in post. A new manager has worked at the home since 2020 and has applied to become the registered manager for the home. This was still in progress at the time of this inspection.
• Management staff understood their responsibility under the duty of candour and were open, honest and took responsibility when things went wrong and notified relevant healthcare professionals and CQC of any significant events at the service.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Continuous learning and improving care

• Records showed feedback from people and relatives was sought through resident and relative meetings. Records showed relatives' meetings were held via video call and areas such as COVID-19 updates, vaccinations, visits, activities and visits from healthcare professionals were discussed. A relative told us, "They have zoom calls every other Friday. The manager keeps us up to date then on things like vaccine supplies, staff testing and how they are managing. Good sessions."
• However, some relatives did tell us as the meetings were held during the day and that it was difficult for them to attend. Three relatives told us when minutes have been requested, these have not been sent. A relative told us, "I'm a bit upset because I don't go to the zoom meetings, but I've asked for minutes or a news sheet and nothing has ever been sent."
• Staff meetings were held to discuss the management of the service. Minutes of these meetings showed aspects of people's care were discussed and staff had the opportunity to share good practice and any concerns they had. A staff member told us, "Yes, there are regular staff meetings. We can all voice our concerns."
• Staff spoke positively about management staff and felt supported in their roles. A staff member told us, "I enjoy my job. I am well supported by other staff and the managers. I work very closely with the deputy manager and they always have time for me. The new manager leaves his door open for the team and has supported us well." Another staff member told us, "It's nice working here. We have very nice managers and staff everyone is supportive. Teamwork is good, the team leaders and managers are very helpful."

Working in partnership with others
• The service worked in partnership with key organisations including the local authorities that commissioned the service and other health and social care professionals to provide effective joined up care and make improvements to the service when needed.
• Where people had issues with their identified health care needs, we saw records confirming that the appropriate health care professionals were consulted with. For example, a staff member told us how they monitored and managed catheter care and when and how they would report any concerns to their manager and the district nurse.

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 12 HSCA RA Regulations 2014 Safe care and treatment Some aspects of people's medicines were not being managed safely. Risks to people's safety in relation to falls was not being managed effectively to minimise the number of falls occurring at the service.