Sudera Care Associates Limited

Ridgeway Nursing Home

Inspection report

Crich Lane
Ridgeway
Belper
Derbyshire
DE56 2JH

Tel: 01773853500

Date of inspection visit:
18 January 2021

Date of publication:
04 March 2021

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
Ridgeway Nursing Home is a care home in Belper, Derbyshire, providing personal and nursing care to 26 people aged 65 and over at the time of the inspection. The service is registered to support up to 37 people.

People's experience of using this service and what we found
The home was not supported by a manager during the inspection. The registered manager and nominated individual were off work due to illness, the provider had not arranged for a person with the required skill or experience to cover this role. The provider had not implemented nationally recognised guidance or shared guidance with staff. There was no system to identify, capture or manage organisational risk. There was poor communication and collaboration with external stakeholders.

We were not assured the provider had guided staff to work within government guidelines for COVID-19 to protect people from the virus. The provider had not kept records to demonstrate the building was a safe environment. Risks to people's safety were not always assessed, reviewed or updated. The provider did not recognise or respond appropriately to abuse or allegations of abuse. Staff were not always supported to complete training.

Staff were kind and caring and relative's spoke highly of them. There were enough staff on duty and we saw staff treated people with kindness and compassion.

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 18 December 2019).

Why we inspected
We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to coronavirus and other infection outbreaks effectively.

We received concerns in relation to infection prevention and control procedures. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Ridgeway Nursing Home 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 and will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to safety, safeguarding people from abuse, staff training, governance and meeting legal requirements at this inspection.

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

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
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 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.

Ridgeway Nursing Home

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
This inspection was carried out by one inspector and one assistant inspector.

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

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. We sought feedback from the local authority and professionals who work with the service. 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.

During the inspection
We spoke with two people who used the service and six relatives about their experience of the care provided. We spoke with 15 members of staff including nurses and care staff.

We reviewed a range of records. This included eight people's care records and multiple medication records.

We looked at three staff files in relation to recruitment. A variety of records relating to the management of the service.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We requested urgent reassurances about the concerns we had identified during the inspection, we looked at training data and staff records. We spoke with four professionals who work with the service.

Inadequate

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 Inadequate. This meant people were not safe and were at risk of avoidable harm.

Preventing and controlling infection

- We were not assured that the provider was preventing visitors from catching and spreading infections. The provider was not supporting the NHS track and trace system.
- We were not assured that the provider was meeting shielding and social distancing rules or promoting safety through the layout and hygiene practices of the premises. We saw people walking and sitting close to each other in communal areas and some staff did not know if people were positive or negative for COVID-19. People who tested negative for COVID-19 were moved to bedrooms upstairs, there was only four bedrooms and no access to a communal living area. The provider had not developed plans to ensure they could accommodate more than four people who tested negative for COVID-19. The provider could not demonstrate that people who had moved to upstairs bedrooms had consented to living with no access to a communal living space, or that these decisions had been made in their best interest.
- We were not assured that the provider was using PPE effectively and safely. We saw staff wore the same PPE all day without changing it, staff told us they had been instructed to take disposable aprons home and bring them back to work the next day because there was insufficient supply to dispose of these.
- We were not assured that the provider was accessing testing for people using the service and staff. The records kept in the home did not demonstrate that people had been regularly offered COVID-19 testing. The provider told us they did not routinely test people for COVID-19 but only sought testing if they developed symptoms. This is contrary to government guidelines.
- We were not assured that the provider was making sure infection outbreaks could be effectively prevented or managed or that people were safely admitted to the service. There were no guidelines documenting how to support people safely during COVID-19 available in the home. Staff told us they didn't know what to do but just did their best. As there were no clear records of testing for people, we could not be assured people had been admitted safely.
- We were not assured that the provider's infection prevention and control policy was up to date. The provider and staff were unable to find this.

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

Assessing risk, safety monitoring and management

- The provider had not always assessed risks to people's safety and some assessments of risk were out of date.
- Staff and relatives told us they did not believe people were always safe and protected from harm. One relative said, "No-one bothers about infection control, the staff are so kind and caring, but I'm appalled by the professionalism of [registered manager]." One staff member said, "The residents are being neglected, we

can't give them the quality they need, we have no idea how to manage Covid, we just do our best."
● The provider had not ensured each person had a Personal Emergency Evacuation Procedure (PEEP). A PEEP is a document that sets out how someone would be assisted to leave the premises in the event of an emergency such as a fire. We asked the staff on duty where PEEPs may be stored, and they told us they hadn't seen any and didn't think the service used these documents.
● The provider was not able to demonstrate the building was a safe environment. The electrical safety records kept at the service were out of date, portable appliance testing had not been done and recommended safety repairs noted on documents from 5 months previously had not been completed.
● Where people's risks were assessed, some documents were unclear as there were two documents stored in a care plan that contained different information. Risks to people's safety, such as falls, were not always reviewed and updated when people's needs changed.
● One person's records showed they had experienced 14 falls before being referred to a health care professional for review.

The provider had not done all that was reasonably practicable to mitigate risk of avoidable harm. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● After the inspection we sought urgent assurances of safety from the provider. The provider did arrange for the electrical safety work to be carried out once we raised this with them. However, the provider did not demonstrate they had made sure each person had a PEEP and this meant they continued to be at risk of harm.

Systems and processes to safeguard people from the risk of abuse
● The provider did not recognise or respond appropriately to abuse. Staff documented when incidents that could constitute abuse occurred, such as altercations between people and unexplained bruising. However, the provider and registered manager did not review the documents staff had completed, did not investigate the incident, refer the incident to the local safeguarding team or discuss the incident with people and their relatives.
● Staff told us they did not feel confident to raise safeguarding concerns with the registered manager because they felt there was a blame culture and the registered manager did not take their concerns seriously.
● The guidance in people's care plans to inform staff how to respond if people displayed behaviours that challenged was not centred towards the person's needs and preferences. We reviewed three care plans for people who displayed behaviours that challenged others and found the guidance was exactly the same. This meant staff were not supported to know how to support people individually or how to ensure they and other people were not upset or injured when people displayed these behaviours.
● There was no safeguarding or whistleblowing policy available in the home during the inspection. This meant staff were not supported with guidance to inform their actions.

Learning lessons when things go wrong
● There was little evidence of action taken in response to incidents or to improve safety.
● We reviewed some incident records detailing people had hurt staff by hitting, biting or scratching them. Other incident records we found included people leaving the home and being found in an unsafe situation, and people placing themselves in unsafe situations by damaging furniture. These incidents had not been reviewed by the registered manager and there was no evidence of an investigation to explore how to ensure the same thing didn't happen again.

The provider had not ensured people were protected from abuse and improper treatment. This was a breach of regulation 13 (Safeguarding) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

● Staff had not always completed or were not always up to date with training. We found some staff had not completed training in moving and handling, infection prevention and control, fire safety or dementia care. Other staff had some training records that had expired more than 12 months before this inspection.

● Staff told us they were not supported to complete training and did not feel confident to care for people during the COVID-19 pandemic. One staff member said, "We don't get any guidance, no-one helps us, we just do our best because we genuinely care for the people who live here."

● There were enough staff on duty to meet people's needs, however there was not always the right mix of skill within the staff. For example, the registered manager and deputy manager were not at work due to illness. The nurse on duty was expected to fulfil the management role as well as being the only nurse responsible for delivering nursing care to the 24 people who required this. One nurse said, "We need support, we need guidance, we need a manager, we're doing everything, we've all been ill with Covid, we're fatigued, we can't keep doing this."

The provider had not ensured staff were supported to undertake training to enable them to fulfil the requirements of their role. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

● Staff managed medicines consistently and safely. Medicines were stored, administered and disposed of safely and accurate records of medicine administration were kept.

● Where people required medicines as and when required, there were clear protocols in place to ensure the nurse on duty was guided as to why this medicine was required, how it should be administered and any potential interactions with other medicines.

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 the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated 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.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- Staff and relatives told us the service was not well-led. There were low levels of staff satisfaction and high levels of stress. Staff told us there was a blame culture and bullying. One staff member said, "Nothing has changed with the manager being off sick, he's never there, if he knows I've spoken to you he'll try to make my life hell." A different staff member said, "The manager isn't ever around but one of the nurses is very intimidating and not approachable, they say things to make you feel small."
- There was no credible statement of vision and values. The provider had not implemented nationally recognised guidance or shared guidance with staff. Apart from the medicines policy there were no up to date policies available in the home for staff to use to guide their practice. The staff on duty during the inspection were unable to locate any policies, including and infection prevention and control policy to guide them about how to care for people during COVID-19.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- Roles, responsibilities and accountability arrangements were not clear. The registered manager had been in post for three years, but staff told us he was rarely present at the home and only arrived on a Sunday evening to profile staff rotas for the following week. One staff member said, "The manager is never there, I couldn't tell you the last time I saw him." A different staff member said, "The manager isn't there to support or guide us, he doesn't do anything." One relative said, "The manager does not take his responsibilities, he needs to man up."
- The home was not supported by a manager during the inspection. The registered manager and deputy manager were off work due to illness, the provider had not arranged for a person with the required skill or experience to cover this role.
- The provider was not and had not been present at the service for the duration of COVID-19, they had not appointed a person to retain oversight of the home for them. When we contacted the provider for support to locate documents during the inspection, they told us they wouldn't know where to find anything and to contact the registered manager whilst they were off sick.
- There was no system to identify, capture or manage organisational risk. We asked the provider to show us quality assurance and audits used by the manager to oversee the running of the home. No-one at the service was able to find these despite staff thoroughly searching all offices and filing cabinets. The registered

manager sent a text message to say audits were kept in the downstairs office cupboard, in there we only found medicine audits, and these had not been completed for six months.

The provider had not implemented effective systems to assess and monitor the quality of care, this included a lack of overall scrutiny at board level. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 provider did not adhere to the duty of candour. Where people had experienced altercations such as being hit by another person the provider did not always ensure people, their relatives and relevant professionals were aware of this. One relative told us they had not been informed when their relation died or been informed been informed that they had tested positive for COVID-19 before they died.

Working in partnership with others

● There was poor communication and collaboration with external stakeholders. The local authority and clinical commissioning group told us before, during and after the inspection that the provider and registered manager did not answer repeated requests for information and did not engage in open and transparent communication with them.

The provider had not acted in an open and transparent way. This was a breach of regulation 20 (duty of candour) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Reporting of incidents, risk, issues and concerns was unreliable and inconsistent. The provider had not submitted statutory notifications to CQC which is their legal responsibility to do so.

● We identified incidents of abuse and serious injury that had occurred at the home and not been submitted as a notification to CQC.

The provider had not submitted notifications of serious injuries or abuse CQC. This was a breach of regulation 18 (Notification of Other Incidents) of the Care Quality Commission (Registration) Regulations 2009

● We identified that the provider had not been notifying CQC when people had died at the home. In 2020 the provider had only submitted notifications about two people's deaths. When we reviewed documents at the home we identified 19 people who we believed had died at the home in this time.

The provider had not submitted notifications of people's deaths to CQC. This was a breach of regulation 16 (Notification of Death of Service User) of the Care Quality Commission (Registration) Regulations 2009

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 16 Registration Regulations 2009 Notification of death of a person who uses services The provider had not submitted notifications of people's deaths to CQC

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider had not notified CQC of serious injury, abuse or allegations of abuse.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20 HSCA RA Regulations 2014 Duty of candour The provider had failed to act in an open and transparent way, they had not informed relevant professionals or people's relatives of notifiable incidents