Mr Kevin Martin

The Radcliffe

Inspection report

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Date of inspection visit:
06 February 2017

Date of publication:
16 March 2017

Ratings

Overall rating for this service	Good

Is the service safe?	Requires Improvement
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

The inspection of The Radcliffe took place on 6 February 2017 and was unannounced. The previous inspection had taken place during November 2015, where breaches of regulations were identified in relation to safe care and treatment and good governance. Following the previous inspection, the registered provider submitted action plans to show how they would address these breaches. We found the areas identified had been addressed and we found improvements during this inspection.

The Radcliffe is registered to provide personal care and accommodation for up to 34 older people; some of whom are living with dementia. The home is made up of two buildings, connected by a covered walkway. One building has 17 en-suite bedrooms and the other building has 17 bedrooms, of which five are en-suite. The home has three communal lounges, two communal dining areas, five communal bathrooms and an enclosed garden and outdoor seating area. There were 33 people living at the home at the time of the inspection.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like 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.

People told us they felt safe living at The Radcliffe. The registered manager and staff were aware of relevant procedures to help keep people safe and staff could describe signs that may indicate someone was at risk of abuse or harm. Staff had received safeguarding training.

Risks to people had been assessed and measures put into place to reduce risk. However, more detailed information and guidance for staff to ensure safe moving and handling of people would further ensure people's safety.

Some improvements were required in relation to fire safety. The registered manager and registered provider were aware of this and had begun to take action.

Medicines were stored and administered appropriately.

Staff told us they felt supported and had received appropriate induction, training and ongoing support and supervision.

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

People received appropriate support to meet their nutritional and hydration needs. A variety of drinks and snacks were offered to people throughout the day.

We observed staff to be kind and supportive and people told us staff were caring. We observed people's privacy and dignity was respected.

Care records were person centred and reviewed regularly. Care and support was provided in line people's care plans. Appropriate information was shared between staff to enable continuity of care.

The registered manager was visible throughout the service during our inspection and they knew people's needs well. Regular quality assurance audits were undertaken and the registered manager ensured that, where actions were identified, these were logged and monitored. There was a service action plan which identified who was responsible for specific actions.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Some action was required to ensure people were safe in the event of a fire.

Medicines were managed and administered safely.

Accidents and incidents were monitored, investigated and analysed.

Robust recruitment practices were followed to ensure staff were suitable to work in the home.

Is the service effective?

Good

The service was effective.

Staff had received training, support and supervision to enable them to provide effective care and support to people.

The principles of the Mental Capacity Act 2005 and associated Deprivation of Liberty Safeguards were upheld.

People received support to access health care services and to meet their nutrition and hydration needs.

Is the service caring?

Good

The service was caring.

People told us staff were caring.

We observed reassuring, positive and caring interactions between staff and people.

People's privacy and dignity was respected.

Is the service responsive?

Good

The service was responsive.

Care plans were detailed and reflected people's preferences, choices and personal histories.

We observed people making their own choices.

Complaints were well managed.

Is the service well-led?

Good

The service was well led.

Quality assurance audits took place to ensure continued improvements.

The registered manager knew people, and their needs, well.

Improvements had been made since the last inspection in November 2015.

The Radcliffe

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.

The inspection took place on 6 February 2017 and was unannounced. The inspection was carried out by two adult social care inspectors.

Before the inspection we reviewed the information we held about the home and we gathered information from the local authority, including the commissioning and safeguarding teams.

The registered provider had been asked to complete a Provider Information Return (PIR). This is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make. We used this information to help plan and inform our inspection.

We used a number of different methods to help us understand the experiences of people who lived in the home, including observations and speaking with people. We spoke with eight people who lived at the home, one relative, six care and support staff, a member of domestic staff, a laundry assistant, the compliance manager and the registered manager.

We looked at five people's care records, four staff files and training data, as well as records relating to the management of the service. We looked around the building and saw people's bedrooms, bathrooms and other communal areas.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe living at The Radcliffe. One person said, "Oh yes. The staff make sure of that." Another person said, "Yes, I do [feel safe]." A further person told us, "I have a buzzer. I ring this if I want the staff. They come reasonably quickly. I have to take into consideration what they're doing." A relative told us, "I have no worries or concerns at all."

The registered manager and all the staff we asked demonstrated a clear understanding of what constituted abuse and the signs to look for which may indicate abuse. The registered manager was clear about the procedures they would follow if they suspected anyone was being abused or was at risk of harm. Records showed appropriate referrals had been made to the local safeguarding authority and the Care Quality Commission (CQC) had been notified in line with the registered manager's duty when incidents had occurred. This showed steps had been taken to prevent abuse and improper treatment.

We found risks had been assessed using a specific tool in relation to weight loss, nutrition and skin integrity for example. Falls risk assessments took into account different factors regarding people's needs, mobility and history and this resulted in a score. Depending on the score, the person was indicated as low risk, medium risk or at risk. For each indicator there was then a description of actions to take. Achievement plans complemented risk assessments and these detailed people's goals, how they would be achieved and what would happen should the plan fail. Having risk assessments and achievement plans in place helped to ensure people could be encouraged to be as independent as possible whilst associated risks were minimised.

Although moving and handling risk assessments had been completed, we found these would benefit from further detail. For example, in one of the care plans we sampled, the information relating to the use of a bath hoist did not contain reference to the safe use of the rails or lap belt. This information would be required to enable staff to safely support the person when bathing. We shared this with the registered manager and compliance manager who agreed they would address this.

The registered manager had subscribed to the principles of the Herbert Protocol. The Herbert Protocol is a national scheme which encourages carers to compile useful information which could be used in the event of a vulnerable person going missing. This demonstrated the registered manager had procedures in place to help keep people safe.

Care plans contained information specific to people's health needs or individual risks and included details of signs, symptoms and how to manage conditions such as vascular dementia and osteoarthritis. They also contained information relating to the risk of pressure sores, how they develop, who is at risk and what staff should do to reduce risk. This helped staff to provide safe care because they were given appropriate information specific to people's health needs.

The fire safety of the building had been evaluated by the fire service in January 2017. Actions were identified as being necessary to reduce risks associated with fire evacuation and the spread of fire. We saw work to

rectify this had begun and the registered manager shared with us their fire evacuation procedures which required further development to take account of evacuation of the building. The registered manager was aware of this and shared their action plan with us, which indicated a specialist consultant was reviewing current documentation.

There was a fire evacuation sledge to assist people to exit the building in an emergency. A member of staff told us, "They've shown me what to do if the fire alarm went off and where to go." There was a secure box in the entrance containing personal emergency evacuation plans and a plan of the building. This helped to provide staff with information they would need in order to ensure people could be evacuated in an emergency situation.

We saw evidence weekly environmental safety checks were undertaken. The gas safety record and Electrical Installation Condition Report were valid. The lift was regularly maintained. We found the maintenance file to be well organised, with a clear indication of the 'next due date.' This helped to ensure the premises were kept safe.

The previous inspection in November 2015 had found accidents and incidents were not being analysed appropriately. We found improvements at this inspection. We saw an accident form had been completed following an accident and this included a timed log and post-accident checks by staff. An analysis of accidents and incidents took place and this considered whether any equipment was being used and the day and time of accidents. This meant any trends could be identified.

There were mixed responses from staff regarding whether staffing levels were sufficient, although all staff we asked told us there were enough staff to keep people safe. A member of staff said, "Yes, staffing's adequate. We help each other if we fall behind." Another member of staff shook their head and said, "We could do with another member of staff." We asked a relative whether they felt there were enough staff and we were told, "It all seems okay." A person we asked told us, "There are enough staff but they are pushed. Especially on an evening."

We observed people's needs being met on the day of the inspection and the number of staff identified as being required by the registered manager were deployed. However, the registered manager did not use a dependency tool and was not able to provide a rationale relating to current staff numbers. The registered manager confirmed, although individual needs were outlined in care plans, there was no overall analysis of people's needs. It would therefore be difficult to determine the numbers of staff required, should people's needs change. We discussed with the registered manager the benefit of analysing people's needs in order to determine staffing levels and be satisfied the numbers of staff deployed were sufficient to meet those needs. The registered manager told us there was an operations manager in post, who would be looking at developing a dependency tool. We saw evidence this had been identified on the registered manager's action plan.

We inspected four staff recruitment files. We found safe recruitment practices had been followed. For example, the registered manager had ensured references had been completed, identification had been confirmed and Disclosure and Barring Service (DBS) checks had been carried out. The DBS helps employers make safer recruitment decisions and reduces the risk of unsuitable people from working with vulnerable groups.

Medicines were administered by staff that had been trained to do so and in a kindly and patient manner. Medicines were stored securely in a locked trolley and a locked refrigerator where this was necessary. We heard a carer who was administering medicines to a person explain to the person what their medicine was

for.

Some medicines, such as paracetamol for example, were administered on a PRN (as and when required) basis. We found PRN protocols were in place. This helped to ensure these medicines were administered appropriately and at safe intervals. We felt the protocols would be more effective if they contained further information specific to the individual, such as where the pain might be felt and how the person might display signs of pain. This would further help to ensure these medicines were administered appropriately. We shared this with the registered manager and compliance manager who were receptive to this and agreed to consider this further.

Some people were prescribed topical creams. We saw body maps were in place which helped to ensure staff applied creams correctly, as prescribed.

We counted random samples of medicines and the balance remaining reconciled with the records.

The home appeared clean and tidy. We observed staff used personal protective equipment (PPE) at appropriate times. This helped to prevent and control the risk of the spread of infection. The Radcliffe had recently been awarded a food hygiene rating of 5, which equates to 'very good.'

Good

Is the service effective?

Our findings

People told us, and our observations found, staff had the appropriate skills and knowledge to support people effectively. One person said of the staff, "They know what they're doing. You're alright here."

The compliance manager shared with us a training matrix which provided an overall view of staff training. This was well organised and showed staff had received training in areas such as moving and handing, infection prevention and control, safeguarding and first aid.

A member of staff told us, "I had a week of shadowing others, watching staff and getting to know people." We saw evidence staff had received an induction which consisted of shadowing and training in essential areas such as fire systems and safety, safeguarding, infection prevention and control and moving and handling. Additional training such as dementia care, equality and diversity, the Mental Capacity Act 2005 had also been completed.

Staff competency was assessed. We found hand hygiene observations had taken place and we saw medication competency assessments had been completed for staff who were administering medicines. This had been implemented following the previous inspection in November 2015. The compliance manager told us these were now being undertaken annually, unless there were any concerns, in which case the frequency would be increased.

The previous inspection found staff had not received regular formal supervision. Staff now received one to one supervision every three months, facilitated by the compliance manager. The staff we asked told us they felt this was useful to them and their development. Furthermore, staff told us they would feel able to request additional training and support if they felt this was required.

The compliance manager was also a moving and handling facilitator. This meant, should people's needs change, safe moving and handling procedures could be assessed and staff training could be provided in a timely manner.

The registered manager had subscribed to a dementia care journal and had made links with a local university. This enabled the registered manager to keep abreast of best practice and ensure the care and support provided was in line with current guidance.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and

hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA. People's consent to care was sought. The registered manager had a good understanding of the principles of the MCA and of how decisions might be made in a person's best interests if they lacked capacity. Mental capacity assessments had been completed for people where it was felt they may lack capacity to consent to care and treatment for example. We saw these assessments were decision specific and detailed. They demonstrated the principles of the MCA had been followed. Where people did lack capacity, we saw evidence decisions were made in their best interests. These decisions took into account the person's history, the views of the person, their relatives or their representatives.

The registered manager had appropriately sought advice and made applications to the local authority for people who were deprived of their liberty. The registered manager had kept a record of any DoLS applications, their outcome, whether they were authorised and the expiry date. This meant that new applications could be made when necessary.

We observed a mealtime experience on both units within the home and we found these to be relaxed and pleasant. Tables were laid with tablecloths, crockery, condiments and glasses. Staff told us, and people confirmed, they were usually offered a choice of two meals. However, on the day of the inspection, take-away fish and chips had been arranged. People chose where they wanted to sit and were assisted to the tables appropriately by staff. Choices were offered to people and these were accommodated. We observed one person requested an alternative meal and this was promptly provided.

Staff were helpful and attentive. Staff asked people whether they had finished their meal before removing plates. One person said, "The food is lovely. You are never hungry." Another person told us, "The food is good," and a further person said, "They come and ask what I want. You get a choice of two." We saw people being offered drinks and snacks throughout the day. This showed people received appropriate support in order meet their nutritional and hydration needs.

Some environmental improvements were evident since the last inspection in November 2015. For example, improved signage was appropriately placed to help people to navigate around the home. People's rooms were personalised and contained photographs and other items of sentimental value. Fresh flowers were displayed in the home and photographs were hung on walls.

We found evidence of referrals to other healthcare professionals such as GPs and district nurses, and requests for medicine reviews when appropriate. This showed people living at the home received additional support when required to meet their care and treatment needs.

Good

Is the service caring?

Our findings

We asked people whether staff were caring. One person told us, "The staff are really caring, they are lovely." A relative told us, "Very happy with the care. They do a great job."

One person said, "It's nice here. Lovely." Another told us, "I like it here."

Comments from a consumer survey of July 2016 included, 'I know that [name] is very fond of some staff,' and, 'The care that [name] receives from The Radcliffe is of a high standard and you couldn't wish for any one nicer than the staff.'

We observed staff acknowledged people and spoke with people when they entered the room.

A member of laundry staff said, "I love it, my job. I care about people's clothing and how they look." A care worker told us, "I love it here." Our observations were that people appeared well care for. Gentlemen were cleanly shaven and people were smartly dressed.

There were times when staff provided support to a person who was displaying repetitive behaviour and who required much reassurance from staff. We observed staff provided care and support in a friendly but professional manner and we did not see any staff showing signs of impatience.

During a mealtime, we noted a member of staff had identified a person was not seated close enough to the table. The staff member asked to another staff member to assist them and together they helped the person to adjust. This was done in a discreet and respectful manner.

Staff described how they protected people's privacy and dignity by knocking on doors and ensuring people had their own their private space. Staff told us they closed doors and curtains to protect privacy if people were being assisted with personal care. We observed staff knock on people's doors.

A member of staff said, "It's their home. We try and keep it as homely as possible."

Another member of staff told us, "I try to encourage people to be independent. I offer them the cloth to wash and give them the encouragement and options to help themselves." We noted a care plan we sampled indicated, '[Name] would like staff to fill the sink and will tend to their upper body independently and ask care staff to support with lower half.' This demonstrated the ethos of encouraging independence was considered at the care planning stage.

We saw information was displayed in the communal areas of the home in relation to advocacy services. An advocate is a person who is able to speak on other people's behalf, when they may not be able to do so, or may need assistance in doing so, for themselves. This meant people could access independent support with decision-making if they needed this.

People's personal and confidential information was kept secure in the office. People were given a choice regarding whether they wished to have a key for their own room. This meant people could be in control of the security of their own belongings.

Good

Is the service responsive?

Our findings

We asked some of the staff we spoke with to tell us key information about the people they supported. Staff were able to tell us people's likes and dislikes and information regarding people's personal histories and families. The information staff shared correlated with the information in people's care plans. This showed care plans were person-centred and staff knew people well as individuals.

We reviewed five care records and found they were easy to navigate and well organised. The staff we asked told us they had time to read people's care plans. Care records contained a photograph of the person and key information at the front of the file. Within the care file was information pertaining to other information such as the person's personal emergency evacuation procedure, details of the involvement of other healthcare professionals, a life history and individual care plans relating to needs such as mental health needs, sensory, mobility, personal hygiene, dressing, continence and night time needs.

Information contained within care plans was detailed and provided staff with the information they required to provide personalised care and support. For example, one plan we sampled stated, 'Do not question why [name] is doing something. Ask [name] what they want you to do.'

We observed a person display repetitive and, at times, behaviour that could be challenging to others. This person's care plan contained specific information to guide staff on how to appropriately support the person. During the inspection we saw staff provided this support as outlined in the plan, with positive effect.

Care plans were reviewed regularly. A relative told us, "We meet about every month with the staff about [name]'s care plan." This showed people's needs were regularly reviewed. However, although care plans were reviewed, we found a lack of evidence to show people had been involved in this process. When we asked the registered manager about this they told us they were already aware of the issue and were looking at ways to address this.

Daily records of care and support were recorded by staff on an electronic system. These were detailed and showed people were supported according to their care plans. Staff accessed the system using their own password. This meant information was secure and records were kept of the support provided.

Staff told us handovers were held in between each shift. A staff member said, "The handovers are relevant. We also have a message book. We read that before each shift." We looked at handover records which showed appropriate information was shared between staff to enable continuity of care when staff changed.

The registered provider employed an activities coordinator, although they were on leave during our inspection. One person we spoke with became animated as they spoke about the activities coordinator and they told us, "He has memory stuff. They brought animals for us to pet. He took me out to a carol service at church." A staff member told us, "[Name] does planned activities. He's really good and does a lot. Holy Communion is every month and we have singers coming in." We looked at the activities planner for the month of February 2017 and saw planned activities included singers, string players, keep fit, quiz, arts

afternoon, bingo, crafts and a dementia class.

We spoke with a person who preferred to spend much of their time in their own room. They told us they preferred to be quiet and on their own but told us, "They keep checking to see if I'm okay." We saw staff offered a choice of drinks and cake and biscuits to the person at mid-morning.

A staff member told us, "People choose when they want to get up or go to bed. It's their choice." We asked people whether they were able to make their own choices and one person told us, "Yes, I do decide what I want to do." Throughout the inspection we heard staff ask people for their choices, such as where they wanted to sit and what they wanted to eat. Another person told us, "I get up when I want to and go to bed when I want. If I want a shower, I get one."

The complaints procedure was displayed. The registered manager explained they were keen to learn from mistakes but also celebrate and share good practice. We saw evidence complaints were handled appropriately and actions were taken and lessons shared where necessary. For example, following concerns that had been raised regarding the laundry service, a larger capacity washing machine had been purchased and staff had received additional training. This showed the registered manager acted upon complaints.

Good

Is the service well-led?

Our findings

The home had a registered manager in post, who had been managing the home since June 2015 and who had registered with the Care Quality Commission to manage the home since August 2015. An operations manager was in post and a compliance manager had been employed since July 2016.

The previous inspection ratings were displayed at the home. This showed the registered manager was meeting their requirement to display the most recent performance assessment of their regulated activities.

When we asked staff whether they felt the home was well-led, a staff member said, "Well-led? Yes, [registered manager] and [operations manager] are very supportive as well." Another member of staff said, "[Registered manager] would pull you up if they saw poor care. They'd let you know. I feel supported though. I wouldn't come if I didn't. I don't have to come."

A further staff member told us, "I'd recommend this home. People are well looked after and, yes, it's well-led," and another said, "[Registered manager]'s very supportive. You can go to her with anything. It's really nice here."

The registered manager told us the values they wanted to promote at The Radcliffe were a caring and compassionate service and said, "It's their home [meaning the people who lived at The Radcliffe]." The registered manager told us they were aware legislation, regulation and best practice were continually changing and they were taking steps to keep up to date with changes through, for example, working in conjunction with a local university and subscribing to dementia care journals. National Institute for Health and Care Excellence (NICE) guidelines were researched and followed.

Staff meetings had taken place, and the last recorded full staff meeting was in August 2016, during which issues such as whistleblowing, hydration and accident recording was discussed. Items discussed in other meetings included team working, recording of information and encouraging independence. The registered manager told us they commenced work each day at a time which enabled them to meet with staff at the handover between the night and day shift. The registered manager had introduced weekly meetings with senior care staff. Meetings are an important part of a registered manager's responsibility to ensure information is disseminated to staff appropriately and to come to informed views about the service.

Records showed managers' meetings were held. Items discussed included the importance of quality assurance, consent, safeguarding, how to access the NICE guidelines and the outcomes of the previous Care Quality Commission (CQC) inspection. We also saw discussion was held regarding updating policies and procedures in line with current legislation.

Since the last inspection in November 2015, the registered manager had introduced quarterly residents' meetings. Records showed these meetings were well attended. Items discussed included upcoming events, feedback on activities and equipment for example. We saw records of one meeting showed people had asked to attend a dementia group. The activity plan we looked at for February 2017 included people's

attendance at a dementia group. This showed the registered manager and registered provider listened to people's views and wishes and acted upon these.

The registered manager had become an Antibiotic Guardian. This is a campaign developed by Public Health England with the aim of taking action in helping to slow antibiotic resistance and ensuring antibiotics work now and in the future. This meant the registered manager was helping to ensure people's health was maintained and antibiotics were only prescribed when necessary.

An operations manager and compliance manager were providing support to the registered manager. The registered manager explained this had enabled them to better develop appropriate policies and to support staff more effectively by providing one to one supervision and support to staff. The registered manager told us they felt the home had improved since the last inspection in November 2015 and they felt optimistic this would be sustained.

The registered manager had a clear action plan which the managers of the home were working towards. This included actions from quality surveys and quality monitoring systems and feedback from staff training and meetings. The action plan identified any actions along with timescales for completion and who was responsible. This meant the registered manager and registered provider had a system in place for continual improvement and areas for improvement had been identified.

The previous inspection found concerns regarding a lack of procedures in the event of emergencies. At this inspection we found the registered provider had policies and procedures in place for emergencies such as in the event of adverse weather, flooding, physical damage, failure of food supply and break-in for example. These included details of emergency plans and who to contact in the event of different emergencies.

We saw monthly audits took place in relation to the environment and any actions required, including a timescale for completing required actions. Monthly medication audits took place and these considered whether records were fully completed, stock levels and any discrepancies were identified and actioned. We saw staff had been addressed when they had not completed records correctly. This showed the registered provider had systems in place for regular audits to enable them to monitor and improve the safety and quality of service.

A consumer survey had been conducted since the last inspection in November 2015. Feedback was mostly positive from the survey and we saw where concerns were raised, these resulted in actions being taken. This showed the registered provider sought and acted upon feedback from people.