Dukeries Healthcare Limited

The Ridings Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
The Ridings Care Home is a residential care home providing personal and nursing care to up to 83 people. The service provides support to younger and older adults living with dementia. At the time of our inspection there were 79 people using the service.

People's experience of the service and what we found
People were not always protected from the risk of harm; we found systems were not effective in reducing risks to people from incidents, the spread of infection or the environment. Systems in place to safeguard people from abuse were not robust and processes for learning lessons were not effective in driving improvements.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

People were not treated in a compassionate, respectful way. People's autonomy, independence and choices were not upheld. People's dignity was not maintained by staff practices.

People's preferences and person-centred needs were not always fully considered and met. Group activities and community visits were facilitated by the service, but access to these was not offered to everyone. Some people spent long periods without any social interaction.

Quality assurance systems were not always effective for people. This meant the action taken by the provider had not always ensured people received consistent, caring and safe support. People did not always experience a positive and empowering culture at The Ridings Care Home.

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 6 February 2020).

Why we inspected
The inspection was prompted in part due to concerns received about the quality and safety of the service, including how the provider was responding to safeguarding concerns. A decision was made for us to inspect and examine those risks.

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

Enforcement
We have identified breaches in relation to how people's safety was managed, how people were safeguarded from abuse, their rights promoted, people being treated with dignity and respect, how people's person-centred needs were met and how the service was run at this inspection.

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
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

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

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

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

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

The Ridings Care 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 Health and Social Care Act 2008.

Inspection team
The inspection team consisted of 3 inspectors, a nurse specialist advisor, 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.

Service and service type
The Ridings Care Home is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. The Ridings Care Home is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

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

At the time of our inspection there was not a registered manager in post. The service had a manager who joined the home in July 2023 and intended to register with CQC. However, since the inspection a new manager is now in post.

Notice of inspection
The 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. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with 13 people and 4 relatives about their experience of the care provided. We spoke with 2 professionals who have contact with the service. We spoke with 20 members of staff including the nominated individual, manager, deputy manager, quality and compliance manager and 16 members of nursing and care staff. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We reviewed a range of records. This included 11 people's care plans, a range of medicine administration records (MAR) and 2 staff recruitment files. We viewed a variety of records relating to the management of the service including audit systems. We spent time observing the care that people received within the home.

Inadequate

Is the service safe?

Our findings

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

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

Assessing risk, safety monitoring and management; Preventing and controlling infection

- People's health risks were not assessed and documented effectively to ensure they were safely managed. For example, people who displayed behaviour that could put themselves and others at risk did not have clear care plans and risk assessments to manage and monitor these risks.
- The environment was not monitored effectively to reduce risks to people's safety. We observed fire doors were routinely propped open by staff, and records indicated this had been highlighted by audit systems for several months. This meant that fire doors would not automatically close in the event of the fire alarm being activated, which could lead to the spread of fire in the building.
- People were not protected from hazards in the environment. We observed clutter throughout the home, such as broken and stored equipment which could cause people to trip or fall. People also had access to items which could harm them such as chemicals or medical equipment.
- People were not supported by effective infection control practices. We observed communal bathrooms that were unsanitary, linen and people's personal clothing stored in dining rooms, and people's slings hung on equipment or with staff belongings. This put people at risk of the spread of infection.
- Staff did not always demonstrate good infection control practices. For example, some staff had painted nails or wore jewellery. We observed staff serving meals without washing their hands first.
- The competency of staff to support people safety was not regularly reviewed. While medicine competency assessments took place, we could not be assured these were completed for all relevant staff. Staff skills in managing other risks, such as moving and handling, were not assessed.

Systems had not been established to assess, monitor, and mitigate risks to the health, safety and the welfare of people using the service. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
The provider took immediate steps to reduce the risk of harm to people, following our feedback.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong

- People who experienced distress, or behaviour that could put them and others at risk, were not safely supported. We observed staff using physical interventions to restrict and control people. For example, people were pushed or pulled to sit down when staff wanted them to stop walking throughout the home. This was not necessary or proportionate for the people involved.
- People were not safeguarded from the risk of abuse. We found several incidents of potential abuse had not been reviewed, investigated and, where appropriate, reported to external agencies. For example, we reviewed incident records where people had unexplained bruising or had made allegations that they had been harmed. No actions had been taken to safeguard those people. This put people at risk of ongoing abuse.

● Learning from previous incidents was not gained, to protect people from ongoing harm. There was no system in place to effectively review information from incidents to prevent reoccurrence. Several incident records for falls stated there were no preventative measures as it was a known risk for the person. No effort was made to review the particular circumstances of each fall and take steps to reduce the ongoing risk.

The provider had failed to take action to safeguard people from the risk of abuse. This was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

● There were not always enough staff to meet people's needs. We observed people waiting for support, including 1 person who was experiencing pain and had to wait for the nurse to give them medicine. We observed a nurse having to run throughout the building to complete their duties. The provider took immediate steps to increase staffing numbers following our feedback.

● Staff had been recruited safely. Pre-employment checks had been carried out including Disclosure and Barring Service (DBS) checks. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Using medicines safely

● Medicines were not always safely stored. We observed prescribed thickeners, which were used for some people's drinks, were sometimes left in communal kitchen cupboards. Temperature checks for the room and refrigerator where medicines were stored were not always recorded.

● People's medicines were administered as prescribed. Medication records correctly reflected the medications people had received and the remaining medications in stock at the service.

● Systems were in place to ensure people's individual medication needs were met. For example, clear protocols were in place for people's 'as and when' medications or if a person needed to take their medications covertly.

Visiting in care homes

The provider was facilitating visits for people in the home. During the inspection we observed several relatives and friends visiting their loved ones.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Ensuring consent to care and treatment in line with law and 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 MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

● Where people had conditions placed on their DoLS authorisation, the provider had not taken action to ensure the conditions were met. We found some people's authorisations had been in place for several months without the conditions being adhered to. This put people at risk of their liberty being restricted disproportionately, which may not have been in their best interests.
● There was a system in place for ensuring DoLS authorisations were sought from the supervisory body when required. However, we found 1 person's authorisation had expired for over a month before a further application was made for a renewal to the DoLS authorisation. This meant the person was unlawfully deprived of their liberty during that time.

The provider failed to ensure people were not deprived of their liberty without the lawful authority to do so. This included a failure to comply with conditions placed on authorisations, which were intended to reduce the deprivation of liberty placed on people. This was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People's capacity to consent to decisions around their care and treatment was not always considered and, if required, assessed and documented. We found 1 person with a cognitive impairment was provided with treatment which would not have been in line with their previous wishes. A capacity assessment and

best interest decision had not been completed to consider this.
● Care plans did not effectively consider and document people's consent. For example, people's records contained a capacity summary document, but these had been completed with people's care needs rather than their ability to consent to that care.
● People's consent was not routinely sought by staff before carrying out care. We observed several examples of staff members carrying out a task without engaging with the person and seeking their consent first.

The provider failed to systematically seek consent from people about their care and treatment. Where people lacked capacity, the provider failed to follow the legal framework of the Mental Capacity Act 2005, to reach decisions in people's best interests. This was a breach of Regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience
● Not all staff had received up to date training in a range of relevant subjects. For example, staff had not received mental health training. Very few staff had completed positive behaviour support training and not all staff had completed challenging behaviour training. This may have contributed to the lack of staff knowledge in supporting people with these needs.
● Staff who supported people, but did not carry out direct care, were not always offered relevant training. The activity coordinators had not had dementia or challenging behaviour training, despite supporting people with these needs to access the community.
● New staff members received an induction; staff files showed inductions had been successfully completed.
Adapting service, design, decoration to meet people's needs
● Some areas of the home needed repair or redecoration. For example, several communal bathrooms had broken toilet seats. One person's personal bathroom was noted to require repairs to the walls and panelling. The handrails in corridors were worn, which would impact the effectiveness of cleaning.
● Consideration had not always been given to adapting the environment to meet people's needs. There were limited aids or displays to support people living with dementia, and orientation boards were not always updated with correct information. We observed 1 person with a sight impairment struggling to navigate around changes in the communal areas such as side tables which had been moved.

Supporting people to eat and drink enough to maintain a balanced diet
● Mealtimes were not always a positive experience for people. We observed staff focusing on tasks rather than engaging with people. Some people who required support with their meals had to wait a long time for staff to help them.
● Care plans contained details about people who required specialist diets. Kitchen staff liaised regularly with the staff team to ensure they had up to date information about people's dietary needs. For example, some people required fortified diets, or had cultural dietary needs.
● Where people were at risk of malnutrition or dehydration, systems were in place to monitor intake and request external support as necessary.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
● People on short term respite placements experienced improvements in their health and abilities while staying at the home. One relative told us, "I do think [my relative] has been happy here. He has improved whilst he has been here. He has started to talk more. He is always clean and tidy when I've arrived."
● People were supported to access external healthcare support, such as vaccinations, eye tests and chiropody. Professionals gave positive feedback about how the service worked with them.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

● People had care plans and risk assessments in place to document their specific health needs. Records showed people with needs such as diabetes, catheter care or modified diets had clear care plans in place. Staff understood these needs and ensured people received the care they required.

● People had individual care plans and risk assessments to consider their oral health needs. Where required, people were supported or prompted to carry out their oral hygiene routine.

Inadequate

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant people were not treated with compassion and there were breaches of dignity; staff caring attitudes had significant shortfalls.

Ensuring people are well treated and supported; respecting equality and diversity; Supporting people to express their views and be involved in making decisions about their care; Respecting and promoting people's privacy, dignity and independence

- People generally told us that staff were kind, but this was not reflected in our observations. We saw several examples of people being pushed or pulled about without communication. One person was shouted at to wake up, after they fell asleep during lunchtime, which caused them distress.
- People were not treated with dignity and respect. One person told us, "They can be sharp with me, I don't think they like caring for me. If they would try and understand me more, then they would understand why I do things. Then they would respect me more."
- Staff members used undignified language to refer to people, such as describing people as 'assisted feeds' or 'shouters'. This reduced people to their needs, and meant people were not seen as individuals.
- People who did not speak English as a first language were not supported to express their views or be involved in their care. Staff members, including the home manager, did not know what 1 person's first language was. This left people isolated and unable to communicate their needs.
- People's privacy was not upheld. We observed 1 person becoming embarrassed when they were asked if they needed the toilet, in front of others. Two people told us staff members did not shut the door when they were using the bathroom. One person said, "I get annoyed as the door is always left open to the bathroom when they support me or wash me in the bathroom. I do tell them. The member of staff said to me "Don't tell me what to do". I'm not happy being here."
- People's autonomy was not respected. We observed 1 person being refused a hot drink, and another person was prevented from going into their room when they wanted a nap. We also observed staff telling a person they would withhold their cigarettes until the person had a shower. This meant people were not treated as adults who could express their own choices and preferences.

People did not always receive compassionate care that upheld their dignity. This was a breach of regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- People's preferences were not always considered and respected. For example, we observed 1 person's room was locked, against their wishes, as staff wanted to prevent them from sleeping in the daytime.
- People on modified diets did not always receive the same meal choices as others at the service. For example, we observed people on soft or pureed diets were not offered cake and cream after lunch.
- People received all their meals and drinks in plastic cups, bowls, and plates. These were used universally throughout the home, rather than based on people's assessed needs. This was not person centred, did not consider individual preferences and infantilised people.
- Choices were not consistently given to all people. For example, not everyone was given the opportunity to enjoy entertainment at the home or to access the community. This meant that some were at risk of becoming socially isolated.
- People spent long periods alone, without engagement. One person's records showed that, other than a monthly entertainer, they had not been engaged in any activities for the last 3 months.

The provider had failed to ensure people had maximum choice and control over their needs and preferences. This was a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Meeting people's communication needs
Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

- People who spoke English as a second language were not always supported effectively with their communication. One person's care plan stated they had picture cards to support them to communicate. However, staff did not know about the cards, and we did not observe them being used.
- People had basic communication plans in place, but the guidance available was not always followed by staff. We observed staff tending to engage with people who verbally communicated, which sometimes left those with additional needs isolated.

Improving care quality in response to complaints or concerns

● The provider sought feedback from people and staff. Results from a recent staff survey were in the process of being analysed, to identify any actions required.
● There was a system in place to record, investigate and evaluate any complaints received.

End of life care and support
● People had care plans in place to consider their individual wishes, values, and beliefs at the end of their lives. At the time of the inspection no one was being supported with end of life care.

Inadequate

Is the service well-led?

Our findings

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

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

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

- Quality assurance systems had failed to identify the areas of concern we highlighted during our inspection. Audits had not been effective in finding the issues we established in relation to the safety and quality of the service. For example, the provider failed to implement robust systems to monitor the safety of the environment.
- Governance systems were not effective in taking action when shortfalls in the service were identified. Prior to our inspection, the Local Authority had highlighted concerns about the quality of the service and provider audits had also identified similar issues earlier in the year. Despite this, limited progress had been made in addressing these areas.
- Systems and processes were not effective in ensuring incidents of harm, neglect or abuse were recorded, reviewed, investigated and, where appropriate, reported to external agencies.
- Governance systems failed to ensure people were not unlawfully deprived of their liberty by adhering to the conditions stipulated on authorisations and applying for new authorisations in a timely manner.
- The provider failed to maintain oversight of the culture of the home and the experiences of people, to ensure caring, person-centred and compassionate care was received by people.
- Systems were not effective in ensuring people's consent was sought for all aspects of their care and treatment.

The provider had failed to implement effective systems and processes to drive the quality and safety of the service. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

- People and relatives knew who the manager and deputy manager was and felt able to raise any concerns they may have.
- Systems were established to seek feedback from people, relatives and staff. At the time of our inspection, a team meeting had been scheduled to discuss the results of a recent survey.
- Professionals reported the service worked well in partnership with them and found the staff and managers responsive to any professional advice or guidance.

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 understood the responsibility of duty of candour. A letter had been sent out to families to explain the findings of the recent audit by the Local Authority.

● Staff were aware how to raise any concerns if they were to arise and felt confident to escalate their concerns should they need to.