Bupa Care Homes (Bedfordshire) Limited

Ridgeway Lodge Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection of this service on 23 May 2016 following the receipt of some information of concern and we found that improvements were required. After that inspection we received concerns in relation to the lack of safe care for people who used the service and the ineffective management of the service. As a result we undertook a focused inspection to look into those concerns. This report only covers our findings in relation to those topics. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Ridgeway Lodge Care Home on our website at www.cqc.org.uk.

Ridgeway Lodge is a residential care home in Dunstable, providing accommodation and support for up to sixty-one older people. At the time of our inspection there were sixty people living at the home, some of whom were living with dementia.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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.

We found that people's medicines were not managed safely, and the staffing levels were not adequate to meet people's needs. Some moving and handling practices carried out within the service were unsafe and had not been risk assessed. This meant that people were not always safe at the service.

The provider had a robust recruitment policy in place and staff had been trained in safeguarding people and were aware of the reporting procedures in relation to concerns they may have.

People, their relatives and staff did not feel listened to by the management team. In addition, the provider's quality monitoring system was not effective in identifying and addressing shortfalls in the service. Improvements were also required in the management of people's care records.

During this inspection we identified that there were breaches of a number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 relating to the safe care and treatment of people, staffing and good governance. You can see what action we told the provider to take at the back of the full version of the report.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their 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?

Inadequate

The service was not safe.

People's medicines were not managed safely.

The staffing levels were not adequate in meeting people's needs.

People's individualised risk assessments did not take into account all areas of risk.

Staff were trained in safeguarding and were aware of procedures to report concerns.

The provider had an effective recruitment policy in place.

Is the service well-led?

Inadequate

The service was not always well-led.

People, their relatives and staff did not feel listened to by the management team.

Improvements were required in the management of records.

The provider's quality monitoring system was not effective in addressing shortfalls in the service.

There was a registered manager in post.

Ridgeway Lodge Care Home

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 23 October 2016 and was unannounced. It was prompted by receipt of concerning information in relation to the lack of safe care for people who used the service and the ineffective management of the service. The inspection was carried out by one inspector from the Care Quality Commission (CQC).

Before the inspection, we reviewed information available to us about the home, such as whistleblowing concerns from staff, concerns from people's relatives and notifications sent to us by the provider. A notification is information about important events which the provider is required to send us by law.

During the inspection we spoke with eight people who used the service, and five relatives of people to gain feedback on the quality of the service. We also spoke with five care staff, the deputy manager and the registered manager.

We observed how care was delivered and reviewed the care records and risk assessments of four people who used the service. We also looked at four people's daily records and checked their medicines administration records. We reviewed records of accidents and incidents, looked at the staff roster and staffing dependency assessment tool. We also reviewed team meeting minutes and looked at information on how the quality of the service was managed.

We spoke with the provider's regional manager after our inspection to discuss our finding and the actions they were taking to address shortfalls.

Inadequate

Is the service safe?

Our findings

Before this inspection we received information that indicated people's needs were not being met safely, particularly around the management of their medicines and the provision of adequate staffing levels.

A relative we spoke with before the inspection raised concerns about the management of people's medicines. They told us that they had found their relative's medicine on the floor on numerous occasions. They were concerned because if their relative did not get their medicines as they had been prescribed it could be detrimental to their health and well-being. We raised this concern with the registered manager of the home and also with the local safeguarding team for investigation. On the day of our inspection, whilst observing people at lunch time, we found a person's medicine on the dining room floor. We brought this to the attention of the staff who were supervising lunch at the time. We asked one of them to explain what action they would take in a similar circumstance. The member of staff told us that they would report it to the management team. They said, "We sometime find them [medicines on the floor] yea." This confirmed that this was not an isolated incident. They also said, "They [People] forget to take their tablets and they end up on the floor. Some team leaders [staff with responsibility for administering medicines] will stay and wait until they [People] have had their tablets and others wouldn't." Another member of staff told us, "They [staff administering medicines] are supposed to stay until they [People] have taken their medication before leaving but clearly they don't." We showed the deputy manager the dropped medicine. They collected it and told us that they were going to follow the correct reporting, recording and disposal procedures.

As there had been reports of other medicines found on the floor, one of which we had previously brought to the registered manager's attention, we looked at records of incident report to ascertain what actions were taken to address the concerns. We found no recorded incidents of medicines being found on the floor. We were therefore not satisfied that measures were always taken to report and address concerns around people's medicines to ensure their safety and well-being. The inappropriate management of people's medicines not only raised risks of poor health for people to whom the medicines had been prescribed, but also to people who could have picked up the medicines from the floor and taken them. This was nearly done by a person who used the service with the medicines we saw on the floor.

Further concerns around the management of medicines were raised by a person we spoke with. They told us, "The other day staff gave me my evening medication for the morning. I said, "Excuse me, you've just given me the wrong medication." They [Staff] said "Oh!" All my medication have the times written on them. Getting the right medication is an issue here plus the fact that I can't have [Controlled medicine for pains] at the time I need it because the manager said there is no one here to give it at [time] and I need it to have a good night's sleep. So I have to take [it] at [time] which is three hours before I need it and I am in pain for most of the night now. I always used to have it at [time] to get me relaxed enough throughout the night. It would be handy if they could sort it."

We brought this to the deputy manager's and the registered manager's attention. The deputy manager told us that this person took responsibility for administering their medicines which was also confirmed by the registered manager. However, the person's controlled medicines were managed and administered only by

the staff. This was noted in the person's care plan and in their medicines administration records (MAR). We reviewed the MAR sheets for this person and found hand written instructions for the use of their controlled medicines which stated, 'take [dosage] every 4 hours', as we had been told by the person. However, this medicine was usually administered only once daily, at night time. There were unexplained gaps in the MAR for every day from 10 October 2016 which indicated that the medicine had not been administered. This confirmed what we had been told and meant that the person had experienced unnecessary pain and lack of sleep because they had not been given their medicine. The registered manager told us that the night staff needed to be trained to administer controlled medicines to people when needed. The person had been at the home for at least 2 weeks and this information was known to the registered manager prior to and since admission yet no action had been taken to meet this assessed need for regular pain relief. This inability to administer medication over the 24 hour period placed the person at risk of harm.

We found that MAR had not always been completed properly. Where people were new to the service, or had been prescribed short courses of medicines, MAR charts had been hand written by staff. There was no evidence of a check being made that the information written was correct. These MAR did not always contain the required information, such as the number of days the course of medicine should last. There were also unexplained gaps in the MAR. This meant that we could not be confident that people had received their medicines as they had been prescribed.

This failure to safely and appropriately manage people's medicines was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and their relatives told us that the staffing levels were not adequate to safely meet people's needs. One person told us, "They are too short staffed. They [Staff] all seem to be rushing and they seem to be struggling to manage the workload. I'm not being treated as I should be." Another person told us, "There isn't enough of them [Staff]." One relative said, "They make a point of telling you they are short staffed quite a lot of the time." Another relative told us, "Staffing levels are often lowest at weekends, but there are often days midweek when staff are clearly overworked and under supported too. The atmosphere of the home has changed, which is a shame, because I do believe staff are really trying their best with the resources they have."

Staff had views similar to that of people and their relatives'. When we asked one member of staff if people were safe using the service they told us, "That depends on what two staff are in here." Another member of staff told us, "They [People] are safe but the night care is not as it should be. Hourly checks are not always done or recorded. The night staff record on the hourly checks [forms] that they had checked [people] and that they [people] were alright when they are lying in bed covered in urine and faeces. Yes, [registered manager] is aware and I think other staff have showed her but she keeps saying, "I'm dealing with it", but nothing gets done. You guys [CQC] should come here at night to see what goes on." Another member of staff told us of an instance where a person who used the service had been discharged. The night staff had recorded that the person had been checked and that they were fine when they were not in the building and were no longer using the service.

Other staff made comments that were very similar and told us that they felt issues were due to the low staffing numbers and a general lack of time to care for people appropriately. The registered manager confirmed that they were made aware of such issues when we spoke with them. They said they were in the process of increasing the number of staff at night in order to address the concerns. The lack of personal care being undertaken during the night breached people's dignity and heightened the risks of infection or the development of pressure ulcers There was, however, no evidence to indicate that any investigation into these allegations by staff had been carried out, or that the local safeguarding team had been notified where

appropriate. There was also no evidence that indicated people's relatives had been notified, where this was required.

We reviewed the staff roster and found that there were nine care staff and two senior staff planned to support people during the morning and afternoon shifts, with four members of staff on duty at night. However, we found that there were only eight care staff and two senior staff working at the time of our inspection. The deputy manager told us this was due to staff sickness on the day of the inspection but relatives and staff told us this was a regular occurrence. A relative said, "Indeed, it often stands out as exceptional when they are fully staffed." This was also in keeping with the information we had received prior to our inspection.

We also reviewed the provider's staffing assessment tool. This took account of the needs of people who lived at the home and the layout of the building to determine the number of staff needed and ways in which they were deployed in order to meet people's needs. We found this was completed regularly and it was in keeping with the number of staff roster to support people. However, the determined staff levels only met people's basic needs such as their support with personal care and nutritional needs. We were told that this was not always done appropriately because of the staffing levels. A relative we spoke with expressed their frustration and told us they suspected people who were cared for in bed might not be getting support with their drinks or meals at the time they required. Another relative told us that they had witnessed a person being supported to start eating their breakfast at 10:15am which was a lot later than the person liked. One relative told us their relative had waited for such a long time for their breakfast that they asked staff for it and were asked to support their relative because the staff were busy at the time and couldn't support the person to eat their meal. We also observed that most of the relatives who visited during our inspection were supporting people with their meals as staff focussed on meeting people's other care needs.

We over-heard a person in one of the units loudly calling out for help. Staff told us, "[Person] shouts out for help and it is because [they] need staff to go in, have a chat with [them] and reassure [them]. But we don't always have the time and that is sad. We just don't have the time." At the time, two staff were going to support a person cared for in bed. This took both staff off the floor and meant that there were no staff in the unit to support other people. At this point we observed one person walking in the corridor who was not steady on their feet and was at risk of falling. Also, the person who was calling out for help continued to do so. We checked on the person who was calling out for help and stayed with them providing reassurance until they settled down. We also observed another person quietly calling out for help. We checked on them as well and found that they needed reassurance because they were somewhat confused due to their health condition.

Amid the constant outcry for help, there was one person who intermittently shouted 'shut up' in response. A member of staff explained, "[Person] is just frustrated. [They] were in tears the other day because the noise kept waking [them] up. [Another person] also kept getting woken up in the night because of the noise." Another member of staff told us, "From my point of view I would be concerned if my mum was living here with the staffing levels as they are. I think we need more staff. The girls [staff] that work here work so hard and do as much as they physically can but we feel we haven't done enough because we don't have the time. Some staff have left here at the end of a shift in tears because they feel frustrated they couldn't give more. We talk about it sometimes after the shifts finished and we feel guilty, we feel bad that we cannot spend time with the residents maybe doing something for them with them other than the basic washing and dressing. I wouldn't want my mum sat there like that. If only we had more time. You feel guilty when you sit there talking with residents because someone else is buzzing [calling] as they need help. We are flying around all over this place. [The registered manager] must be aware."

Staff confirmed they had raised this as a concern with the management team but felt action was yet to be taken. We raised our concerns with the registered manager and were told, on the day following our inspection, that action had been taken to increase the number of staff deployed to support people during the day and at night.

However, we found that there were insufficient staff to meet people's needs and this had a the negative impact it had on people's experience. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were at risk of harm as inappropriate moving and handling practices were used. We found that people who needed to be transferred using a hoist did not have their own slings. This meant that people were supported to transfer with the use of shared slings. This was evident when we saw a number slings stored in one of the bathrooms without any way of identifying whose they were. Staff confirmed that slings were shared by people. This presented possible risks of infection or falls from heights if an inappropriate sling was used. We found that people's risk assessments did not give staff sufficient information, such as the right sling to be used, to reduce the risk of harm to them. The provider's regional manager told us on the day after our inspection that, "Staff know that slings should not be shared but from today everybody [who live at the home] has their own sling."

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had a robust recruitment policy in place which included checks with the Disclosure and Barring Service (DBS) to ensure that applicants were suitable to safely care for people. Applicants were required to complete health questionnaires to ensure they were fit for the role they applied for. The provider also requested previous employment references. This supported the provider to determine whether applicants were suitable for the roles they were being considered for and that people would be cared for by staff who were suitable to do so.

These were missed opportunities to undertake risk assessments of people's needs in ways that promoted their independence. For example, there was a person who was able to take their own medicines that included insulin with minimal staff support. However, the registered manager told us that the person was not able to administer their controlled medicines because it was risky. This should have been risk assessed and the appropriate support or supervision put in place which would promote the person's independence. There were no assessments to support why this person was unable to manage these risk factors or if they lacked the capacity to do so. Health and safety risk assessments were however in place to safely manage risks posed to the people by the environment.

People and their relatives told us that apart from the staff concerns, the service was safe. One person said, "It is a case of getting used to it but I am safe yes. A relative told us, "It is a great place apart from the issues raised." The provider had an up to date safeguarding policy in place and staff had been trained on safeguarding people. There was also an up to date whistleblowing policy that gave staff guidance on reporting concerns within their workplace. Staff had effectively raised concerns they had about the service to the CQC.

Inadequate

Is the service well-led?

Our findings

Part of the concerning information we received before our inspection was in relation to the management of people's care and the service. There was a registered manager in post, they were supported by a deputy manager, the senior care staff and the provider's regional manager in providing leadership of the service.

People we spoke with and their relatives told us they felt improvements were required in the way the service was managed. From their comments it was evident that much of the impact of the low morale and frustrations of staff was permeating across the home and was known to people and their relatives. A person told us, "Problem is the managers are not communicating properly with the carers." One relative said, "What I would like to emphasise is that Ridgeway has some excellent staff at all levels. For example, the deputy manager is always kind and supportive as are most others. However, we have all noticed a deterioration in the level of staffing and in their motivation since the new manager was appointed. The previous manager would lead from the front. If they were short staffed or particularly busy, she would be hands on supporting them. She knew when there were issues because she was out on the floor listening and observing and being part of the running of the home. She also worked alternate weekends and clearly didn't ask staff to do anything she couldn't step in and do herself. This meant that everyone, including staff, team leaders and family felt that they were all part of the caring environment. She always made time for residents and made sure that staff knew they could too. My observation is that staff are less well supported now and come in when they are unwell because sick pay is at the discretion of the manager, who is quick to put staff on disciplinary including for reporting in sick."

Staff told us they felt undervalued, unappreciated and unsupported by the management team. They said their concerns about the service were not listened to and that there was a blame culture with the management team not taking responsibility for shortfalls in the service provided. One member of staff told us, "Sometimes we feel we are banging our heads against a wall [raising concerns with management]. I think the [registered] manager should work a shift in one of the units and see exactly what we are having to go through. [Deputy manager] is supportive and will come to help when needed." Another member of staff said, "A lot has changed with the new manager. The workload has increased because residents' needs have increased but staff numbers have not changed to accommodate the needs of residents. If staff are complaining about something management don't take it into consideration, they just continue doing what they are doing. One other member of staff told us, "It is always busy here. The staffing levels are an issue. We have complained to [registered manager] and she says, "I'm deal with it," but nothing is done. You can tell [registered manager] till you're blue in the face and she will look right through you and nothing will ever be done about it. The [staffing] level is just an accident waiting to happen."

From discussions we had with staff, we identified that they were able to talk with the management team on an ad hoc basis to air their views. Staff also confirmed that they received regular supervision and had team meetings which gave them a platform to raise their concerns. We reviewed the minutes of the staff meetings that took place within this year and found some discussion about the some of the issues noted in this report. For example, it was noted in the minutes of the meeting of 21 January 2016, "Day staff finding residents in bed wearing day clothes – discussed reason why this might occur, team work and the

importance of documentation and handing information over from shift to shift. To be raised at night staff meeting." It was also noted on the minutes of the meeting of 19 May 2016, "Link [additional member of staff who works in between units providing support when needed] downstairs, not in budget. At times struggle with turns [position changes of people cared for in bed]." It was also noted, "Please do not leave units unattended. If struggling, please let us know to support." Contrary to this, a member of staff we spoke with told us, "[Registered manager] doesn't know what is going on. She says she will come to help when we need her but when we ask she's busy. Why can't she close the office door and come to help? Residents are more important than office work."

An additional area of concern was in relation to the appropriate recording of people's care. We found that the management team had implemented a system of recording care that was given to people such as position changes, food and fluid intake and hourly checks, to make sure these were actually delivered. Staff we spoke with told us that these were not always completed as appropriate, due to a lack of time. A relative we spoke with also told us that this was an issue. They said that they had seen staff backfilling the documentation for hours that they had not checked on people. They said the checks were also not effective as they were just visual checks and not always included checking if people needed personal care or to be supported with food or drinks. We confirmed that there was an issue when we saw that one person's hourly checks had not been recorded for a three hour period on the day of our inspection. The person's position was also not changed in this time to ease pressure. We also found conflicting information in some people's care plans. For example, a section of one person's care plan stated they needed to be transferred with the use of a stand-up hoist, and another section stated a full-body hoist. The impact of this was a discussion we witnessed where staffing debated what hoist they were to use. The wrong one was nearly used.

The provider had a quality monitoring system in place and the management team carried out regular audits. However, these audits failed to capture and address the shortfalls noted within this report. Even though we had raised our concerns about some of the shortfalls, such as medicines management, with the provider prior to our inspections adequate action was not taken to address them. The provider's 'quality matrix' that formed part of their audit system measured people's care in four key areas namely 'quality of care', 'people's quality of life', quality of leadership and management', and 'quality of the environment'. This was designed to identify and reduce incidents such as falls, spread of infection and the development of pressure ulcers. The ineffectiveness of the quality monitoring system was highlighted by the day to day practices, such as the sharing of slings that the management team should have identified and corrected. Also, when we reviewed the record of incidents and accidents we found there had been numerous unwitnessed falls. This was a clear indication that the staffing levels needed to be reviewed but this was not done. As a consequence people have not received the quality of care that they should have been given.

The failure to adequately manage concerns in the service delivery was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 The provider failed to safely manage people's medines

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Adequate action was not taken by the management team in addressing shortfalls in relation to staffing and the management of people's medicines to ensure safety.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staffing numbers and deployments were not adequate in safely meeting people's needs.