Northamptonshire County Council

Ridgway House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Ridgway House is a residential care home providing personal and nursing care for up to 35 people with dementia, mental health, physical disabilities and sensory impairments in one adapted building. At the time of the inspection 25 people were using the service.

People's experience of using this service and what we found
Risk assessments required improvement. Not all known risks to people had documented risk assessments in place. However, staff knew people well and knew what to do to keep them safe.

Medicine administration required improvement. Medicine administration records did not always contain enough detailed instructions on them to ensure staff had all the relevant information to give medicines as prescribed.

Oversight of the service required improvement. Not all concerns found on inspection had been identified. The provider had recently completed an audit and was in the process of putting actions into place to improve the quality. However, this had not been completed during the inspection.

People were supported by kind staff who knew them well. All staff had been safely recruited and received regular support from the management team.

People were protected from abuse, systems and processes were in place to identify and report any abuse or harm.

People were protected from infection. Staff wore appropriate personal protective equipment and the home appeared clean and odour free.

Complaints were dealt with appropriately and people knew how to complain if they needed to.
The management and staff were open and transparent throughout the inspection. They agreed to ensure changes were made to improve the service.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was good (Published 26 April 2019)

Why we inspected
The inspection was prompted in part due to concerns received about care and support. As a result, we undertook a focused inspection to review the key questions of safe and well-led only
We reviewed the information we held about the service. No areas of concern were identified in the other key

questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.
The overall rating for the service has changed from good to requires improvement. This is based on the findings at this inspection.

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

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Ridgway House on our website at www.cqc.org.uk.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to risk assessments, medicines and oversight of the service at this inspection.

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

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.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Ridgway House

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out by two inspectors.

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

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
We gave a short period notice of the inspection. This supported the service and us to manage any potential risks associated with Covid-19.

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.

The provider was not asked to complete a provider information return prior to this inspection. This is

information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

We used all of this information to plan our inspection.

During the inspection
We spoke with five people who used the service and three relatives about their experience of the care provided. We spoke with ten members of staff including the manager, area manager, senior care workers, care workers and domestic staff.

We reviewed a range of records. This included seven people's care records and multiple medication records. We looked at three staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records.

Requires Improvement

Is the service safe?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement: This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management. Using medicines safely

- Not all risks to people had a risk assessment in place. Although staff were aware of the potential risks, we found one person who was at risk of choking did not have a risk assessment in place, people who could not use their call bells did not have risk assessments completed and we found hourly checks put into place to check people's safety were not consistently recorded. This put people at risk of not receiving the care they needed in the way they needed it because staff did not have all the information they needed to keep people safe.
- People who had identified risks regarding skin damage did not always have skin integrity care plans, or recorded checks in place. The information regarding how often the person required repositioning and the records of repositioning tasks were not consistent. This put people at risk of pressure damage.
- People's daily food and fluid charts were not consistently tallied up to ensure they had received adequate fluids. People who required fortified milkshakes did not have the optimum amount documented within care plans. However, we found no evidence of harm.
- Medicine administration records required improvement. When staff transcribed a medicine or change to medicine, best practice had not always been followed. Two staff had not always signed or dated the changes made. We found no evidence of harm.
- Prescribed thickener had not been signed as administered and had not been consistently recorded as given to people who required it. Staff told us and we witnessed staff using thickener appropriately.

We found no evidence that people were harmed, however, the provider had failed to assess all risks to service users and to ensure the safe and proper management of medicines. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- When administering medicines to people staff followed good practice guidance. Staff changed gloves between administration, they explained what medicines were being given to people, staff respected people's right to refuse and respected people's dignity throughout the medicines round.

The provider had completed an audit and action plan the day before inspection which had identified these concerns and was in the process of implementing changes to reduce the risks.

Staffing and recruitment

- Staff were recruited safely. The provider completed pre employment checks such as references and Disclosure and Barring Service (DBS) checks. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults, to help employers

make safer recruitment decisions
● Staff received appropriate training and induction to ensure they had the relevant skills to support people appropriately.
● We found adequate staffing levels on the day of inspection, and rotas confirmed suitable numbers of staff on shift.

Systems and processes to safeguard people from the risk of abuse
● Systems and processes were in place to protect people from abuse. Unexplained bruising had been investigated and recorded appropriately.
● Staff received training on safeguarding and understood how to recognise and report abuse.
● People told us they felt safe at Ridgeway House.

Preventing and controlling infection
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises. However, cleaning schedules did not identify if 'high touch areas' were cleaned regularly to prevent the spread of infections.
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was meeting shielding and social distancing rules.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was accessing testing for people using the service and staff.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.

Learning lessons when things go wrong
● Accidents and incidents were recorded, and trends and patterns were identified to support learning and to make changes as appropriate. For example, after trends were found to a person falling, they were offered a different bedroom to reduce the risks.

Requires Improvement

Is the service well-led?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement: This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people. Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements. Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- Systems and processes to ensure effective oversight of the service required improvement. Audits had been completed by the registered manager, but some were out of date in line with the provider's procedures. For example, the last pressure care audit was completed in February 2020.
- We found some care plans contained conflicting information which could put people at risk of receiving unsafe care. For example, one person's care plan stated they could walk, however this person's needs had changed, and they now required hoisting, their care plan also contained conflicting information regarding food and fluid monitoring.
- The medicines audit had not identified the lack of staff signing of prescribed thickener.
- The provider had not completed any formal surveys or feedback for people, staff or relatives, however they told us that people's views were always sought during reviews and meetings held.

We found no evidence that people were harmed, however, the provider had failed to assess, monitor and improve the quality of the service. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The provider had completed a quality audit the day before the inspection and had identified similar concerns found by inspectors. However, the action plan had only just been written so no actions had been completed.
- The staff understood people's individual needs. People and relatives told us that staff responded to people and were kind. One relative told us, "The staff are loving and caring towards [person] and always try their upmost to put [person's] best interests at heart". People told us they were happy at Ridgway House.
- People were kept up to date regarding changes and improvements being made to the service. One person told us of the staffing changes occurring and what the plans were for the environment.
- Relatives told us they were kept up to date with relevant information regarding their loved one. A relative said, "We were included in everything and still are, COVID permitting."

Continuous learning and improving care. Working in partnership with others

- All staff involved were open and transparent throughout the inspection. Concerns raised during feedback

were considered and actions put into place.
● The provider had plans in place for improvements to the environment and service delivery
● We saw referrals were made to external professionals as required and their advice was followed.

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
● Complaints were appropriately recorded and managed. People and relatives told us they knew how to complain, and when they had concerns these were listened to and the concerns rectified.
● The registered manager understood their responsibility under the duty of candour. The duty of candour requires providers to be open and honest with people when things go wrong with their care, giving people support and truthful information.

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 assess all risks to service users. The provider failed to ensure the safe and proper management of medicines.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to assess, monitor and improve the quality of the service.