The Alder Health Care Group Limited

Radcliffe Gardens Nursing Home

Inspection report

11 Radcliffe Gardens
Pudsey
West Yorkshire
LS28 8BG

Tel: 01132564484

Date of inspection visit:
03 October 2018
04 October 2018

Date of publication:
12 March 2019

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 3 and 4 October 2018. At our last inspection in June 2018, the service was in breach of three regulations. These were regulation 12, safe care and treatment, regulation18, staffing and regulation 17, good governance. We rated the service as inadequate.

We undertook this focused inspection in response to concerns we received about the service which related to fire safety. We also wanted to check that the necessary improvements had been made and to confirm that the location now met legal requirements. This report only covers our findings in relation to those requirements. We found that the service was still not meeting the legal requirements and remained in breach of the three regulations. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Radcliffe Gardens Nursing Home on our website at www.cqc.org.uk.

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

Radcliffe Gardens Nursing Home is registered to provide accommodation for up to 20 people who require nursing or personal care. The home is located in a quiet area of Pudsey and close to local amenities, shops and churches. The home is on two levels with lift access and has a garden area and car parking to the front of the building. At the time of this inspection, 17 people were using the service and all were receiving nursing care.

The service had a manager in post but they were not registered. 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.

The provider had failed to complete all works relating to an enforcement notice served on them by West Yorkshire Fire and Rescue Service in June 2018.

People remained at risk because the provider had not provided staff with proper equipment and training to enable them to support people safely in the event of a fire. Staff did not have opportunities to practise the action they would take in relation to fire safety and this meant people's safety could not be assured.

Staff told us they were not confident about the action they would take if there was a fire at the service. They said they needed training and equipment to ensure they could support people safely.

People's personal emergency evacuation plans (PEEPs) were not up to date and did not include proper guidance for staff. They referred to equipment which was not available within the service, and did not anticipate people's moving and handling needs.

Fire evacuation floor plans for the service were not up to date. They included people who were deceased and did not include a recent admission to the service, or a move of bedroom of one person.

The provider now had a dependency tool in place. We were not assured this meant the service was staffed appropriately as it did not include all of the current care needs of people using the service.

There were no contingencies in place to cover shortages in nursing staff. This meant staff had worked excessively over their contracted hours.

Care staff had completed training regarding the management of medicines but their competency had not been checked. Competencies for nursing staff could not be located at the time of the inspection.

The provider and manager had not operated effective governance systems to ensure that the safety and quality of the service were adequately monitored and improvements made when required.

The provider had not communicated with staff about the concerns at the service. Staff told us they felt they were not valued by the provider, and their views were not included about the running of the service.

Relatives told us they were not aware of the issues at the service relating to fire safety. They said the provider had not provided them with any information about improvements that were needed.

Staff had not communicated with one person who had to move to a different bedroom because their bedroom did not meet fire safety regulations.

The overall rating for this service is Inadequate and the service remains in 'special measures'.

The service 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.

We found three continued breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. 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.

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 safety needs were not responded to by the provider.

The provider had not ensured that staff were skilled and had the equipment they needed to assist people in the event of an emergency.

The provider did not have sufficient contingencies to ensure shortages of nursing staff were covered. There had been no checks undertaken to ensure the competency of staff administering controlled drugs.

Is the service well-led?

Inadequate

The service was not well led.

There was no registered manager in post which is a requirement of the provider's registration.

The provider's governance of the service remained ineffective.

People remained at significant risk because the provider had failed to take sufficient action to address all areas of concern.

The oversight of the service by the provider remained inadequate. This included the leadership and management of the service.

Radcliffe Gardens Nursing 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 checked 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.

We undertook an unannounced focused inspection of Radcliffe Gardens Nursing Home on 3 and 4 October 2018. This inspection was done to check that necessary improvements had been made by the provider after our comprehensive inspection on 5, 8 and 20 June 2018. The team inspected the service against two of the five key questions we ask about services: is the service safe and is the service well led. This is because the service was not meeting some legal requirements.

No risks, concerns or significant improvement were identified in the remaining key questions through our ongoing monitoring or during our inspection activity so we did not inspect them. The ratings from the previous comprehensive inspection for these key questions were included in calculating the overall rating in this inspection

The inspection was carried out by two adult social care inspectors. The visit on the 3 October was carried out at night between 9pm and 10.45pm. We returned to the service the following day.

We reviewed other information we held about the service, including the notifications we had received from the provider, including those in connection with deaths, safeguarding concerns and serious injuries. We also contacted the fire service and local authority commissioning teams for the service.

We spoke with one person using the service, five staff, the cook and the manager. We observed how staff interacted with people and looked at a range of records which included the care records of four people and medication records for all of the people using the service. Records relating to the management of the service

were also reviewed. Following our inspection, we spoke with two people's relatives by telephone.

Inadequate

Is the service safe?

Our findings

At our last inspection, we found the provider was in breach of regulation 12, safe care and treatment and regulation 18, staffing. There were a number of issues relating to fire safety and the lack of fire safety equipment for use at the service which had not been provided by the provider. Staffing levels were not sufficient at all times and there was a risk that people's needs could not be met and their safety compromised. Staff had not completed appropriate training to ensure they were skilled and competent to assist people in the event of an emergency. We have used our powers in an attempt to ensure the provider takes the necessary action to address our concerns. This action is still ongoing and we will publish the outcome of this when all processes have been concluded. At this inspection, we found the provider had failed to address the areas of concern and people using the service remained at significant risk of harm.

Following a visit from the fire service in June 2018, the provider was issued an enforcement notice. This meant they were required to carry out works on the premises and with their staff team to ensure they complied with fire safety regulations. We found that although some works had been completed, other areas of work had not been done. This included the service still not having a detailed zone plan in place so that in the event of a fire, staff could quickly locate the exact location of the fire, intumescent strips had not been fixed to doors within the service, and key safes had not been fixed to the outside of the premises to allow the fire service to gain entry. One person had to move out of their room as it was deemed unsafe by the fire service and the provider had failed to take action to address this.

The provider had failed to ensure staff had fire evacuation aids to use to support people safely in the event of a fire. Staff had also not completed appropriate training to ensure they had the skills they needed. This included practical training aspects of fire training and practised evacuation. One staff member told us, "If there was a fire here at night, you would just have to use your own common sense, get out who you can, without risking your own life." This meant people and staff remained at risk because the provider had failed to take appropriate action to ensure their safety.

Each person who used the service had an 'evacuation risk assessment' which identified the level of support and number of staff they would need to assist them in the event of a fire. However, we saw these did not contain appropriate guidance for staff to follow. For example, the plan for one person stated staff were to use a blanket to evacuate them. The person concerned had moving and handling needs which meant staff may not be able to assist them without equipment to ensure their safety. Staff also told us they did not know which blanket the assessments referred to. Staff told us there were people using the service who they believed remained at risk because of the lack of action taken to address the concerns.

The service remained in breach of Regulation 12 Safe care and treatment, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection, the provider had failed to complete a five year electrical safety test at the service. Following further requests made to the provider, we received confirmation that a five-year electrical safety test was completed for the service.

Staffing levels were of concern at our last inspection in June 2018. Since then, the provider had worked closely with the fire service and increased the numbers of staff on duty at night from two to four. At this inspection, we visited the service at night on the first day of our inspection and found night staff numbers had been reduced from four to three staff with no clear explanation for this. Following our inspection, and after a visit from the local authority, the provider increased the night staff numbers back up to four.

Staff on duty confirmed they had not completed checks on the communal lounge area at night, and were unaware of any reason why they would need to. The provider had not communicated to staff that this was an action required by the fire service to provide additional safety checks for people.

At the last inspection we found that staffing levels were not provided in line with people's needs. The manager told us the provider had instructed them to complete a dependency tool for the service. We saw the document had been completed for July and August 2018, but the manager was unable to confirm what impact this had on the service. The tool also did not take into account people's care needs at night when most people required the assistance of two staff. We saw staffing numbers remained the same during the day since our last visit with some gaps in the rota where numbers could not be maintained. The manager told us they often worked on the floor and was counted in the numbers to help support staff.

Nursing staff told us they were worried about gaps in nursing cover on the rota. They said these shifts could only be covered by the service's own staff as they were not permitted to cover shifts with agency staff. There were gaps in the rota for nursing cover in the next seven days following our inspection. The manager told us they had contacted the provider about this who said they would arrange for the shifts to be covered. Following our visit, we were told that one nurse had worked more than 65 hours in one week with one shift of 24 hours. This was due to lack of nursing staff cover at the service. This demonstrated the provider did not have sufficient contingencies to ensure shortages of nursing staff were covered.

At our last inspection we found the service did not manage people's medicines safely. Work had now been completed which ensured guidance for staff was in place for when they administered 'as required' medicines to people. Care staff had completed training to ensure they could assist nursing staff with the administration of controlled drugs. However, when we spoke with the manager, they confirmed that there had been no checks to ensure the competency of care staff in this area. This meant the provider could not assure themselves that care staff were skilled in this area of their role.

The service remained in breach of Regulation 18 staffing, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We walked around the service and found it was clean and tidy. We spoke with a domestic staff who told us they had the cleaning products they needed but were unsure at times about what would be delivered to the service. This related to paper towels and hand wash. We saw these were in place where required. Bathrooms and storage cupboards were stocked with personal protective equipment for staff to easily access when supporting people. This showed us breakouts of infection could be minimised and contained with the equipment supplied.

Two members of staff were being recruited at the time of our visit. The manager was not able to locate all records relating to this but we saw that appropriate checks had been completed. Therefore, we remain assured that safe recruitment processes are in place.

The manager confirmed there had been no accidents or incidents since our last inspection. We did not identify any concerns previously therefore we remain assured that incident reporting systems continue to be

safe.

Inadequate

Is the service well-led?

Our findings

At the last inspection we were concerned there was a lack of oversight of the service by the provider. They had visited the service only once in the 18-month period prior to our inspection. We judged this level of input by the provider was not adequate and people were put at risk because they did not have proper oversight of the service. At this inspection, we found the provider had failed to provide an adequate level of input and the service remained lacking in leadership. There was a lack of coordination between the provider and the manager in attempts being made to improve the service.

Staff told us they continued to feel unsupported and not valued by the provider. They said they did not know what was happening with the service. They knew about the fire service and CQC visiting but did not know about what actions had been taken, and what if anything, they needed to do. Staff reported their dissatisfaction to us about the lack of engagement with them and the service by the provider and they said they felt worried about the future of the service.

Relatives we spoke with had not been communicated with about the concerns found by the fire service. They told us they had heard rumours about fire safety concerns. They found our last report very worrying and were upset that they had not been approached by the provider.

None of the people using the service had been engaged with about the issues at the service. One person who had to move rooms because their room was unsafe told us they did not know why they had been moved, but they were not happy about it. This demonstrated the provider had continued in their lack of oversight and engagement with the service at a level which impacted negatively on people, relatives and staff.

The provider's quality assurance system remained ineffective at driving improvements within the service. Audits had not been completed with any regularity since our last inspection. For example, a monthly medication audit had only been completed once on 30 August 2018. One care plan audit had been completed for one care plan on 6 September 2018. There was no evidence of actions being put in place to address where shortfalls were identified.

As we found after our last inspection, the provider continued to be unresponsive at times to our requests for further information to be sent to us. When we asked to be updated on any progress made at the service we did not always receive this information.

Since our last inspection, the provider had recruited a new manager for the service. They had not submitted an application to register with us. The service does require a registered manager. The deputy manager continued to work as a nurse in the numbers. This also included the supervision of nursing staff and acting as a clinical lead for the service. The provider had not ensured the deputy manager was given the time they needed to carry out their role effectively.

The service had held a resident and relatives meeting in September 2018. The manager attended but the

minutes we reviewed showed they did not take the opportunity to engage with people and their relatives about the ongoing concerns at the service. Relatives suggested that the provider of the service was notified of the content and outcomes of the meeting. The manager told us they did not know if this had happened.

The manager did not have a clear picture of works which were outstanding at the service. Because these were mainly related to fire safety, this meant people remained at risk. The manager told us they did not have any control over organising works, paying for works and arranging agency cover. They told us all bills were dealt with by the provider. The manager was able to obtain quotes for items of equipment needed but we saw no action was taken after they had submitted these to the provider.

The manager told us that they felt unsupported by the provider. They said that at times they felt they did not know where to start in attempting to address the concerns. They had completed a dining experience audit but agreed that this was not an area that required attention, and there were more urgent areas that needed to be focused on.

The manager told us they were responsible for arranging and carrying out fire drills at the service. The service needed to complete fire drills to ensure staff had the opportunity to improve their competency in relation to assisting people in the event of a fire. Two had taken place since our last visit on 7 and 29 September 2018; neither of these were at night. The records of these did not contain any detail other than a list of attending staff. The manager confirmed that no further fire drills were booked. This meant any areas of improvement such as staff competency, could not be identified.

The manager was unable to provide evidence to support several pieces of work they said they had completed. They told us they had regular discussions with staff about fire safety and in particular, evacuation procedures at the service. There were no records to show the discussions had taken place. Staff told us the manager often talked about fire safety but not in a meaningful way that would aid their understanding and knowledge.

We found further issues relating to record keeping. Fire evacuation documents showing floor plans were displayed and kept within the fire file. We found three versions of these were available for staff. One contained the name of a person who had died recently. Another did not show that one person had moved to a different room. The third did not show a recent admission to the service. This meant the arrangements in place for keeping records up to date were not robust.

Throughout the inspection, we continued to identify areas of concern and evidence to support the failings by the provider to address areas which had required immediate action. We judged that people using the service remained at significant risk of harm and we placed urgent conditions on the provider's registration. With the assistance of the local authority the provider met these conditions within the designated timeframe. However, we have prevented them from admitting people to the service until we can be assured that people are safe.

The service remains in breach of Regulation 17 good governance, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service continued to liaise with other health care professionals where necessary about people's care.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to take appropriate action to address all areas of concern relating to fire safety at the service. People were at risk because the provider had failed to ensure fire safety equipment was in place at the service. The provider had not provided staff with appropriate training relating to fire safety.

The enforcement action we took:

We took enforcement action to cancel the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to ensure the service had effective oversight and leadership. Ineffective governance systems remained in place. The provider could not demonstrate they had taken a coordinated approach in their attempt to address the breaches of regulation following the last inspection. They had failed to drive improvement at the service.

The enforcement action we took:

We took enforcement action to cancel the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to ensure staff were skilled and competent to assist people in the event of a fire at the service. The provider had not ensured there were

adequate contingencies in place to cover shortages in nursing staff at the service.

The provider could not assure themselves of care staff's competency in relation to the management of medicines. Records relating to competency checks for nursing staff were not available to view.

The enforcement action we took:

We took enforcement action to cancel the providers registration.