Anchor Trust

# Ridgemount

## Inspection report

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## Ratings

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|---|---|
| Overall rating for this service | Requires Improvement |

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

# Summary of findings

## Overall summary

We last carried out a comprehensive inspection of Ridgemount in May 2017 where we found the registered provider was rated 'Good' in each of the five key questions that we ask.

This inspection took place on 18 May 2018 and was unannounced.

Ridgemount 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. Ridgemount is a care home service without nursing for up to 66 older people, some who may have dementia. At the time of our inspection 55 people lived here.

There was not a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. This is the third inspection in a row where Ridgemount has not had a registered manager in post. A manager was in post after our last inspection, but they left the service before completing the registration process with CQC.

During this inspection we found that the lack of a registered manager had impacted on the staffs ability to maintain a good rating across the five key questions. The management arrangements to cover the lack of a registered manager had not been effective at supporting the staff to maintain a good rating. A long serving member of staff had just been promoted to manager within the home, and they had begun the application process to become registered with CQC. The manager was at the home during the time of our inspection.

People's safety could not always be assured. We identified three issues during our inspection when we asked 'Is the service safe?' Risks of harm that had been identified were not always well managed to ensure people were kept safe. We identified that improvements were required in how staff managed people's medicines. Staff deployment around the home on the day of our inspection meant that there were times during the day where numbers of available staff fell below the minimum specified by the provider.

Where complaints and comments had been received the staff had not always responded or recorded how things would be corrected. People knew how to make a complaint.

People's access to activities had been impacted by the loss of two activities coordinators. The provision of activities was under review by the manager to ensure people did things that were meaningful and of interest to them. One replacement activities coordinator was going through the induction process and the manager said they were still recruiting for a second.

Staff received an induction when they started at the home and ongoing training, tailored to the needs of the people they supported. However staff did not always put into practice what they had learned.

People's experience of accessing relevant healthcare professionals to maintain good health was inconsistent. Some people were referred to specialists in good time, however other people had not been referred by staff as quickly as they could have been.

The provider had not always completed an appropriate assessment of people's ability to make specific decisions for themselves. We made a recommendation that the recording of where best interest's decisions had been made for people could be improved. Where people's liberty may be restricted to keep them safe, the provider had followed the requirements of the Deprivation of Liberty Safeguards (DoLS) to ensure the person's rights were protected.

People told us they found the staff to be kind and caring and respected them. However, some felt that because staff moved around the building from shift to shift they weren't able to build relationships with them. We observed some interactions which showed a lack of attentiveness by staff to people's needs. We also saw some good interactions by staff, such as holding people's hands and giving comfort when they were upset. People were involved in their day to day care decisions. Processes to support people at the end of their lives needed to be improved.

People and staff were involved in improving the service, but this was not always used to make improvements. The management liaised with outside agencies to review and make improvements to the service.

The provider had carried out appropriate recruitment checks to ensure staff were suitable to support people in the home. Staff understood their duty should they suspect abuse was taking place. There was an ongoing safeguarding investigation at the time of our inspection and the provider was working with the local authority safeguarding team.

In the event of an emergency people would be protected because there were clear procedures in place to evacuate the building.

The home was clean and staff practiced good infection control measures. This included washing their hands, hygienic cleaning of the environment and equipment and correct use of personal protective equipment.

Before people moved into the home, their needs were assessed to ensure staff could provide the care and support they needed. Adaptations had been made to the home to meet people's individual needs. These included large open communal areas and bathrooms to suit individual requirements.

People told us they enjoyed the food. They received a balanced diet and they were encouraged to keep hydrated. People had enough to eat and drink, and specialist diets either through medical requirements, or personal choices were provided.

During the inspection we have identified five breaches in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the 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.

The staff had not always identified risks to people's health and safety or put guidelines in place to minimise the risk. Staff did not always follow the guidelines when they were in place.

The deployment of staff around the home meant that at times people had to wait for care and support.

People's medicines were not always managed in a safe way.

People felt safe living at the home. Staff understood their responsibilities around protecting people from harm

Appropriate checks were completed to ensure staff were safe to work at the home.

Infection control processes ensured people lived in a clean environment.

### Is the service effective?

**Requires Improvement**

The service was not always effective

People had access to health care professionals for routine check-ups, or if they felt unwell, however sometimes staff hadn't made referrals as quickly as they could have.

Training was not always effectively implemented by staff. However, staff said they felt supported by the registered manager, and had access to supervisions and appraisals.

Improvements were required with regards to the systems around recording people's capacity to make or understand specific decisions.

Where people's liberty may be being restricted, appropriate applications for DoLS authorisations had been completed.

Peoples needs had been assessed prior to coming to the home, to ensure those needs could be met.

People had enough to eat and drink and had specialist diets where a need, or preference, had been identified.

Adaptations had been made around the home to meet people's needs.

## Is the service caring?

**Requires Improvement**

The service was not always caring.

There were occasions where staff were task focussed and not attentive to people. People said that the staff moving from unit to unit also impacted on their continuity of care.

Staff knew the people they cared for as individuals. We saw good interactions by staff that showed respect and care.

People could have visits from friends and family, or go out with them, whenever they wanted. People's right to practice their faith was respected and supported by staff.

## Is the service responsive?

**Requires Improvement**

The service was not always responsive.

Information on how staff would support people at the end of their lives was very brief and required improvement.

The complaints procedure had not been effective at ensuring complaints were investigated and action taken to resolve the issues.

Care plans were not always updated to reflect people's current needs.

Staff offered some activities that matched people's interests. However, these were limited due to the absence of two activities coordinators.

## Is the service well-led?

**Requires Improvement**

The service was not always well-led.

The home had been without a registered manager for 10 months.

Quality assurance checks were not always effective at ensuring the home was following best practice.

Feedback was sought from people via meetings and annual surveys, however effective action had not always been taken in response to the feedback received.

Staff felt supported and able to discuss any issues with the manager. The manager regularly spoke to people and staff to make sure they were happy.

The manager understood their responsibilities with regards to the regulations, such as when to notify CQC of events.

# Ridgemount

**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.

Why we inspected - This was a routine comprehensive inspection which we had brought forward as we had received two concerns about the service, and the home did not have a registered manager in post. The concerns were around care and support after a person had been admitted to hospital, and the home did not have enough staff to meet people's needs. This inspection took place on 18 May 2018 and was unannounced.

The inspection team consisted of three inspectors and two experts 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.

Before the inspection we reviewed records held by CQC which included notifications, complaints and any safeguarding concerns. A notification is information about important events which the service is required to send us by law. This enabled us to ensure we were addressing potential areas of concern at the inspection.

The provider had completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. This information was reviewed to see if we would need to focus on any particular areas at the home.

We spoke with thirteen people who lived at the home, four relatives and eight staff which included the manager who was present on the day. We observed how staff cared for people, and worked together. We also reviewed care and other records within the home. These included seven care plans and associated records, seven medicine administration records, two staff recruitment files, and the records of quality assurance checks carried out by the staff.

We also contacted commissioners of the service to see if they had any information to share about the home.

Requires Improvement

# Is the service safe?

## Our findings

People told us that they felt safe living at the Ridgemount. One person said, "I do miss my own home but the one thing I know is…I'm safe…because there are lots of people around." Another person said, "Yes, I feel safe and I'm being looked after."

Although people felt safe, we identified three issues around how people's safety was managed. Risks of harm had not always been managed in a safe way; the management of people's medicines did not always follow best practice and staff deployment meant that some people had to wait to receive care and support when they needed it.

People were not always kept safe because the risks of harm related to their health and support needs had not always been addressed by staff. Two peoples' falls risk assessment and falls care plan had not been updated after falls had taken place. If this had been completed the providers risk assessment process would have generated a falls prevention plan. This is a tool used to review a person's needs and minimise the risk of further falls. As people's needs changed the staff had not ensured that risk assessments were updated and that appropriate equipment was in place to support people.

Another example of failure to identify and manage risks to people was seen during the inspection. Staff did not notice one person struggling to get by a walking frame that had been left in the entrance way of a lounge area. The person also used a walking frame to mobilise so was at risk of falls. Staff were in the same room, but talking amongst themselves so did not notice the potential risk of harm.

Accidents and incidents were reviewed to ensure people had received appropriate care at the time, however as we have identified above, staff did not always follow up from this to make improvements when things had gone wrong. A record of accidents and incidents was kept and the information reviewed by the manager to look for patterns that may suggest a person's support needs had changed. Some incidents had prompted an appropriate response by staff. One relative said, "My family member has been prone to falls, but since she has been at this service she has fallen a lot less because staff have focussed on making sure, as much as possible, that she isn't in situations where she is at risk of falling."

Risks around people's medical support needs had not always been managed in a safe way by staff. One person was an insulin dependent diabetic. There was no care plan or risk assessment in place to give guidance to staff on how to support the person with this aspect of their life. For example, guidance around the signs of hyperglycaemic attack (caused by high blood sugar levels) or hypoglycaemic attack (caused by low blood sugar levels). A nutrition care plan did have some brief information as it stated that the person was on a, 'diabetic diet, low in fat and sugar;' however we observed the person eating sugary biscuits and there were regular entries in their daily notes that they had biscuits. Staff explained that the person could have plain biscuits, however we observed the person eating chocolate biscuits.

This person also had regular high blood sugar levels. High blood sugar levels can bring about a need for frequent urination, drowsiness, nausea, extreme hunger and/or thirst and blurring of the vision. This person

was being supported by staff to manage their diabetes with insulin. However, we noted that their daily records showed their blood sugar levels were consistently high in the afternoons. A senior staff member who gave insulin to people confirmed that they should be calling the GP if a person's blood sugar levels were over a particular range. The range given by the staff member matched the range that the person's blood was consistently at. They were not able to explain why a GP had not been called to review this person's insulin levels and ensure their diabetes was managed in a safe way. After the inspection the provider explained that the person's blood sugar had been high due to the time the test had been completed. However, this did not negate the fact that the staff had not responded to the high levels of sugar in a person's blood. No plan of care to address the time the blood was tested and that this level of sugar in a person's blood was deemed acceptable were in place. Staff told us that their training identified that blood sugar levels this high should have resulted in the GP being called.

People's medicines were not always managed in a safe way. Where people had medicines given via patch there was no guidance for staff on where to position the patch. This is important as patch placement should be alternated to reduce the risk of inflammation of the skin, and poor absorption of the medicine through the skin. Records of when staff had given medicines were also incomplete with gaps in the medicine administration records. It was then not easy for staff to see if people had been given their medicines as prescribed.

The storage of medicines was not always safe. A pharmacist advice visit carried out in February 2018 identified that on occasion the storage of medicines in some units of the home exceeded 25 degrees Celsius. The pharmacist recommended that, 'Staff to consider alternative storage if this persists.' Records reviewed during the inspection demonstrated that the temperature had been in excess of 25 degrees on a number of occasions in March, April and May. The temperature had been above the recommended limit nine times in March 2018. In addition, staff had not always recorded the daily temperature check, so the frequency of these high temperatures of medicines could not be easily determined. A staff member who gave medicines to people confirmed to us that the medicines should not be stored above 25 degrees. No action had been taken by staff to ensure the excessive temperatures where affecting the medicines, nor had they responded to the recommendation made by the pharmacist. The provider took action after the inspection to address the issue with the storage of medicines by purchasing air conditioning units for the areas where medicines were stored.

Failure to do all that is reasonable practicable to mitigate risks to people's health and safety and the failure to manage people's medicines in a safe way is a breach in regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were not always sufficient staff deployed to support the health and welfare needs of people when they needed. One person said, "Some (staff) of them at night don't really help. They will get you up if you ring the bell, they put you on the toilet and then leave you and they don't come back for a long time." A relative said, "Usually (there are enough staff) sometimes at the weekend they can be short." One staff member said, "On the ground floor definitely not (enough staff) as there are a lot of people who need feeding and people have to wait. The floater (spare member of staff) should be around more." They added, "Some of the team leader's help (but not all of them)." People did have to wait for staff support during the inspection because staff were not always available to help them if needed. For example, during lunch one person was supported by staff to eat in their room. The staff member had to break away from this to support another person to the toilet -. After that they assisted another staff member to transfer a person from their wheelchair into a chair. They returned to the person to help them finish their meal 15 minutes later, and had to reheat the meal as it had gone cold. No other staff had come to assist the person as they were not available during this time. After lunch there was a period of time when there was only one staff member on the top floor and the middle

floor (wing two). This was because their colleague was on their hour-break lunch. A staff member told us, "It's fine because people are sleepy after lunch and it's calm." However, this level of staffing did not match the providers calculated minimum safe level of two staff.

Staffing levels were based on the individual needs of people. The manager confirmed that since the last inspection in May 2017 they had reviewed how dependency needs were calculated. This was to ensure staffing numbers were adequate to be able to provide care without rushing people. Staffing rotas recorded that the number of staff on duty matched with the numbers specified by the manager. Our observations over the day of the inspection demonstrated the numbers of staff on shift met with the provider's minimum safe level. However, their deployment around the building meant at times the actual staff on each floor dropped below the provider's minimum safe level, to just one staff being available to support people, rather than two.

Failure to deploy sufficient numbers of staff at all times to meet people's needs is a breach in regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were protected from the risk of abuse. Staff had a clear understanding of their responsibilities in relation to safeguarding people. One staff member said, "I would fill in the correct forms and document it. I'd inform families and pass it on to management and social services." Information with the details of the local authority safeguarding team and 'whistle-blowing' line were displayed around the home. These were a reminder to staff and people about who they could contact if they had concerns. Where allegations had been made, the manager had made the appropriate referrals to the local safeguarding authority and followed their instructions on investigating or taking other actions to keep people safe. There was an ongoing safeguarding investigation at the time of our inspection and the provider was working with the local authority safeguarding team.

People's care and support would not be compromised in the event of an emergency. Information on what to do in an emergency, such as fire, was clearly displayed around the home and people took part in fire drills. People also had personal evacuation plans, which were understood by staff, that detailed the support and equipment they would need if they had to be evacuated from the building.

Fire safety equipment and alarms were regularly checked to ensure they would activate and be effective in the event of a fire. Emergency exits and the corridors leading to them were all clear of obstructions so that people would be able to exit the building quickly and safely. There was also a continuity plan in place to ensure people would be cared for if the home could not be used after an emergency.

Appropriate checks were carried out to help ensure only suitable staff were employed to work at the home. The management checked that potential staff were of good character, which included Disclosure and Barring Service (DBS) checks. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. We did identify missing information on the day of the inspection, such as references, however these were found and sent to us after the inspection

People were cared for in a clean and safe environment. Assessments had been completed to identify and manage any risks from infection to people around the home. Staff ensured the floors and doors were kept clean. Equipment such as walking frames were regularly serviced and cleaned to make sure they were safe to use. Staff wore appropriate personal protective equipment when giving personal care, or when serving food to minimise the risk of spreading infection. The sluice rooms on both ground floor units were locked to prevent unauthorised access and we noted both units were clean. People's rooms were seen to be clean.

Carpets looked freshly vacuumed, and beds were clean and neatly made. The rooms smelt fresh with no malodours.

Requires Improvement

# Is the service effective?

## Our findings

People's experiences of receiving effective care and support were inconsistent. Although staff had received training to give them the knowledge and skills to enable them to care for people, they did not always follow or remember this training. Staff had received training in safe moving and handling however we saw two occasions were staff used inappropriate lifting techniques to help people move from wheelchair to armchair. These were reported to the manager close to the time they happened, so they could investigate and stop any further reoccurrence.

Staffs knowledge around responding to specific needs such as diabetes and epileptic seizures was also variable. The lack of guidance in care plans for people with epilepsy contributed to this. For example, staff told us that they would always call an ambulance if someone had a seizure. While this would be effective at keeping the person safe in an emergency, staff we spoke with had no knowledge of the potential signs a person may display when they were about to have a seizure or the potential triggers. Factors such as length of time of the seizure and the individual needs of the person can all contribute to whether an ambulance is required or not. Staff knowledge around weighing people who spent all their time in bed was also inconsistent. One person was on a monthly weight chart; however, they had last been weighed in October 2017. Monthly entries by staff since then had written, 'bed bound' on them. There was no evidence of measuring their weight any other way. Staff we asked were not able to explain how a person's body mass index could be calculated by using other techniques, such as those explained on the Malnutrition Universal Screen Tool guidance. This tool was widely used in the home to monitor a person's risk of malnutrition.

It is recommended that the manager review the effectiveness of staff training to ensure what has been learned is effectively put into practice by staff.

New staff received induction training to ensure they had the core skills to care for people. One staff member said, "I did the Anchor induction, training and e-learning. I already had NVQs so didn't need to do the care certificate. I shadowed for two weeks." Ongoing staff training and refresher training was well managed, and the manager ensured staff kept up to date with training in accordance with the providers requirements.

People received support to keep them healthy; however, people's experience was inconsistent. On occasion staff had not been as prompt as they could have been to refer people to specialists. One person told us, "I've been asking all week if I can see a doctor – I've got a pain in my leg." One person had been steadily losing weight since December 2017. Staff had not responded to this by calling the GP, or seeking guidance to place the person on a fortified diet until the second of May 2018. Another person had an eye test in August 2016 with a note in the care records for a review in a year. The records did not contain any information to confirm this had taken place. A third person was seen by the GP early in May and referred for a blood test. No records of the outcome where available in the persons file to demonstrate if this had taken place, or needed chasing.

It is recommended that the provider reviews their healthcare referral processes. They must ensure effective action is taken and recorded in response to people requesting access to healthcare professionals. In

addition they should ensure that results of appointments and referrals are known and actioned if necessary.

Other people experienced a good level of effective care. One person had clear nutrition plan in place and their weight had remained stable. Good examples of effective support were also described by relatives. A relative said, "My family member has diabetes and the staff have managed to get her off the medication for this by changing her diet." Another relative said, "My family member had a slight pressure sore but straight away she was seen by the district nurse, and their bed and mattress were changed for an air mattress."

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. Where people had relatives with power of attorney (PoA) to make decisions on their behalf the provider had a copy of the PoA document. This enabled them to be sure that people making decisions had the legal right to do so.

Where people lacked capacity to make certain decisions, basic assessments had been completed. We did note that these were generic, for example three different people had the phrase 'Can the customer understand the need for care?' as the only decision being assessed in their care plan. There had been an inconsistent approach to other decisions made on people's behalf. One person had signed their own consent to care form, as they had capacity to understand why they lived at the home. However, a staff member had signed their consent to self-medicate topical creams, with no record of if the person was unable to agree to this themselves. Another person did not have capacity to make a decision to move into Ridgemount. They only had a best interest record for the decision for them to stay in their previous Anchor home, rather than at Ridgemount.

It is recommended that the manager review the recording and assessment of people's mental capacity to ensure they are up to date and reflect the current needs of people.

Care staff had an understanding of the MCA including the nature and types of consent, people's right to take risks and the necessity to act in people's best interests when required. Staff asked for people's consent before giving care and support throughout the inspection.

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. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). Where people's liberty was restricted to keep them safe, appropriate applications had been made to the DoLS Board. People were supported in accordance with these DoLS authorisations. Examples such as people not having the capacity to make a decision to live at the home had been addressed under the DoLS.

People's needs had been assessed before they moved into the service to ensure that their needs could be met. People told us they felt they had been involved in this process. This involved meeting with people and those important to them. Areas covered included eating and drinking, sight, hearing, speech, communication, and their mobility, as well as personal preferences and histories. The assessments also reviewed people's specific needs to see if there were any specific legislation or standards that needed to be met, such as their rights under the Equalities Act.

People lived in a home that had adaptations made to meet their individual needs. There was a lift available

for people to reach the upper floor, and specialised chairs and pressure mattresses were available for those at risk of skin wounds. The provider had upgraded the facilities in a number of bedrooms to meet the changing needs of people. For example, 60% of the bedrooms now had ensuite 'wet rooms' to cater for peoples reduced mobility. The home was open and spacious with plenty of different communal areas which people could access.

Staff told us that they felt supported in their work. Staff had regular one to one meetings and annual appraisals which took place with their line manager. One staff member said, "We get supervisions where we talk about what we need help with." This enabled them to discuss any training needs and get feedback about how well they were doing their job and supporting people. Staff told us they could approach management anytime with concerns, and that they would be listened to and the management would take action.

People had access to a range of food and drink to keep them healthy. During the inspection people were offered snacks in-between main meals, for example finger foods such as diced cheeses and fruits in addition to biscuits with their teas and coffees. People were overall complimentary about the food, with some saying it had recently improved. People were involved in the menu and selection of meals, such as during resident's meetings where the chef attended. During the inspection we made positive observations of people being offered choice. During lunch people were given time to select their meal, and they were also shown it on the plate to enable them to make an informed choice.

People's special dietary needs were met, such as soft diets for people who had difficulty swallowing. One person required a gluten free diet and they told us "I am happy with the choices provided to me." A relative said, "My family member has to have pureed food which she doesn't really like but she's got problems with swallowing, so there's no other option really. She does get the same meal as everyone else [but in a different format]." Food and supplements stored in the kitchen matched with people's preferences and dietary needs. These reflected what people had told us and the staff had a good knowledge of people's individual requirements. Items such as specialist 'soft' sausages that were braised were provided so that those on fork mashable diets could still have sausages in a form that looked like a normal sausage on their plates.

Requires Improvement

# Is the service caring?

## Our findings

Although staff were generally kind and attentive towards people throughout the inspection, we did identify some areas for improvement. People told us that there was often no continuity of care because the staff moved between all the different floors. We observed this happening during the inspection when staff moved between the different floors. It did not happen just to cover people's breaks but was a routine occurrence. This meant that the people did not know staff as well as they might. One person said this affected them as, "I don't feel I have anyone that I could talk to – I can't really talk to the carers about intimate things." Another person said, "I prefer it when I have the same staff supporting me." Relatives gave us similar feedback. One said, "A lot of staff don't have their name badges on so you don't know who they are."

Staff were sometimes task focussed and were not very attentive to people during our inspection. We observed that some staff would sit on a chair in the corner of a room where most people were present. They had little interaction with people during these times. When supporting people to eat, some staff were observed to have little or no interaction with the person they supported. Another lack of attentiveness by staff was shared by the relatives of two people. They told us about peoples clothing being mixed up, so that people had been dressed in clothing that did not belong to them. In one instance a person who required staff support to dress was found by their relatives to be wearing size 16 trousers (when they were a size 8). These kept falling down. This showed a lack of attention to detail by the staff who had supported the person to get dressed.

People had an inconsistent experience in being supported to maintain their independence. One person said, "I'd sooner do the things myself." A relative said, "The idea is that they keep their independence and they build their confidence up again and staff do that." However, during the day of the inspection there was very little activity around promoting independence, for example people were not involved in food preparation, or making their own drinks. One staff member explained that they did try to give people their independence. They said, "One client loves make up and dressing up. I helped her put on lipstick and foundation when she was feeling very down."

We recommend that the manager reviews people's experiences and opinions of care so issues they may have can be addressed.

There were some positive aspects to the care people received. One person said, "The best thing about living in this service is that the staff are very nice and helpful." Another person said, "They are all very nice here." A relative said that the service was, "Fantastic" that they were, "Really pleased" and that they (staff) maintain, "Great communication" with him. They also said they felt they had a, "Really good connection with all the carers" and that, "All the staff know me by name." Staff were seen to talk to people whilst carrying out their duties, or taking time away from their duties to talk with them. When one person spilled their drink and immediately became very upset, staff were quick to respond, and tell them that it wasn't a problem. They calmly cleaned up the spillage and spoke to the person in a low calming voice, which calmed the person down. One staff member was overheard talking to a person about their favourite dance (as the person used to be a ballroom dancing teacher). Care records recorded personal histories, likes and dislikes, and matched

with what staff had told us.

Some of the staff we spoke with were knowledgeable about people and their past histories. One of them said, "We have a keyworker system here so the staff get to know the clients' needs well." They went on to say, "We do move units but people do get some consistency." These staff were able to tell us a lot about the people they supported without access to the care notes, including their hobbies and interests, as well as medical support needs.

People were given information about their care and support in a manner they could understand. Information was available to people around the home, such as the correct time and date to help people orientate themselves. Other information on notice boards covered topics such as upcoming events that people may be interested in, as well as photographs of past events that people had enjoyed.

People, where ever possible were involved in decision making about their care. A staff member went up to one person and asked how their leg was, as they had complained of pain previously. Staff discussed with the person and said, "Let's walk up and down the corridor and see how you feel?" The person accepted and took the staff member's hand and they slowly walked out the room. The staff reassured the person and provided encouragement and talked about what they wanted to happen as they walked up the corridor.

Staff treated people with dignity and respect. One person said, "Most of them are quite pleasant in that way." Another person said, "I had an awful attack of diarrhoea and the staff were really good and weren't bothered that they had to clean me and it up." Staff demonstrated respect for people's privacy and dignity during the inspection. One staff member told us how they supported a, "Claustrophobic lady who had asked me to leave the toilet door ajar for her. I said to her, I will stand in the space where the door isn't shut so people can't see in." This gave them privacy and respected their independence while respecting their personal phobias.

People's rooms were personalised which made them individual to the person that lived there. People's needs with respect to their religion or cultural beliefs were met. Staff understood those needs, and how the person's care may be affected due to those beliefs. People had access to services inside and outside the home so they could practice their faith. People told us they could have relatives visit when they wanted.

Requires Improvement

# Is the service responsive?

## Our findings

Improvements were required to ensure that as people approached the end of their lives all their needs and requirements would be known. At the time of our inspection no one was being supported at the end of their life. End of life plans that were in place contained little information on how care and support should be given. For example, one recorded, 'To go into a nursing home,' while another stated, 'Catholic, arrange priest. Daughters to sort.' A third recorded, 'Contact my son – he will arrange.' The manager said people's families would be involved and consulted and they planned to develop detailed plans for people as the need arose. This would not give staff the necessary information on how to support a person as they approached the end of their life, especially if this came on suddenly. A further care plan stated that a person followed a faith however their life story document stated they had been an atheist all their life (and still were at the time of the inspection). This could cause inappropriate care and support to be given to this person at the end of their life.

Care plans were based on what people wanted from their care and support, however these were not always reviewed and updated to match the needs of people. One staff member said, "Some of the care plans need updating." One person's care plan stated that they needed to wear surgical stockings daily. However, staff told us these were no longer used. Reviews of care had been completed monthly by staff. They completed a form to document this review. However, all these forms were blank for this person and showed no changes. This was despite the change regarding the surgical stockings. Another person's care plan recorded that 'Staff to offer [name] plenty of fluids to reduce risk of urine infection'. The person had a history of urinary tract infections (UTIs) however a fluid chart was not being used to record the persons input and output, nor was there a target amount of fluid the person should try to drink each day. The risk of people not receiving responsive care was increased as one staff member said, "Daytime handovers did not always happen." They described how this could have had a possible impact on people's care. They said, "I wasn't on the other unit for a while and when I went back I thought [person name] was in hospital because I didn't see her. It was only later another carer told me she was now bedbound, otherwise I wouldn't have known." Another example of care plans not containing information around people's needs was given when a staff member said, "I have discovered a person is claustrophobic. This needs to be put in their care plan. I am not sure what we are going to do when the activities are upstairs as they won't be able to use the lift." Because this had not been recorded in the persons care plan they could become distressed if a staff member that did not know them took them into the lift.

People's care and treatment did not always meet their needs nor reflect their preferences. This is a breach in regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Recording of complaints was inconsistent so the provider could not be assured that all complaints were resolved to the satisfaction of the people who made them. There had been two complaints recorded in the last year. These related to staff attitude for one person, and an issue with staff practice when providing care for the other. Both had been in 2017, and actions had been recorded to show they had been resolved. However, in one person's care review records in May 2018 it stated they had raised concerns about 'night

staff forgetting to fix their catheter when they came home from hospital so they got wet.' We asked the manager about this who confirmed this happened but could not give any information about how this had been followed up with staff, nor why it was not included in the complaints record.

The system for receiving, recording and handling complaints had not been effective at ensuring all complaints were investigated. This is a breach in regulation 16 (Receiving and acting on complaints) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
People told us they felt staff would listen to and would respond to complaints or comments. A relative said, "The reception staff [person's name] and [person's name] they are very welcoming and friendly. I would probably go to them first if I had a concern." Another relative told us, "They are proactive…the minute I say anything that they haven't noticed themselves, it's acted upon."

There was a complaints policy in place that was clearly displayed around the home. The policy included clear guidelines on how and by when issues should be resolved. It also contained the contact details of relevant external agencies, such as the Local Government Ombudsman.

People's access to activities to keep them entertained and stimulate their minds was inconsistent. There was a variety of information displayed around the home, showing people taking part in many different activities. However, with the loss of the two activities co-ordinators the variety and frequency of activities had decreased. On the day of our inspection most of the activities on the units consisted of watching television, or listening to music. Many people were seen to be dozing both in the morning and the afternoon with little stimulus from staff. The manager explained that one new activities coordinator was going through the induction process and further interviews were planned to fill the second vacant post. A staff member told us that each unit planned its own activities and that there was a member of staff in each unit who, "Is good at activities." The staff member said that on their unit they did it because they enjoyed doing it and they knew the people and what they liked. The staff had also completed a training activity course, which involved learning how to engage people in activities. One person said, "We do have activities…we went upstairs yesterday for some Bingo and downstairs the other day for some music. The staff are very good they always take me. I wouldn't be able to get there on my own." Another person said, "In the summer they have planned for lots more activities…on the whole it's a good home." Recruitment of two replacement activities co-ordinators was underway at the time of the inspection.

Requires Improvement

# Is the service well-led?

## Our findings

The home had been without a registered manager for nearly ten months at the time of our inspection. Although a manager had been in place they had not completed their registration with the CQC prior to them leaving. There had not been a registered manager in place at either of the two previous inspections carried out in 2015 and 2017. The manager who was in post at the time of this inspection had been at the home for many years and had acted up as manager during periods where the home was without a permanent manager. The lack of a consistent registered manager at Ridgemount has impacted across all five of the key questions we asked during the inspection.

Comments from people also reflected on the inconsistency of management at the home. One person said, "I don't even know who's in charge here." Another person said, "I find in a lot of ways that they're very lackadaisical here." Other people gave a more positive response, especially with the appointment of the new manager. A relative said, "I'm really pleased (he's now manager). He is established and knows the place and the people."

During the inspection the manager was observed to engage with people and staff across the building, however this had not been effective at picking up issues with staff practice, or identifying the issues we have identified, nor the comments from people and their relatives.

Regular weekly and monthly checks on the quality of service provision took place, however actions raised by these checks were not always well managed by staff. An infection control audit completed in April 2018 recorded that staff were to offer people hand hygiene (washing hands) prior to meals. During our inspection we observed people being offered finger foods, and moving from the lounge to dining areas with no offer of having their hands washed prior to eating. A pharmacist audit had identified an issue with storage of medicines. The providers own internal checks had not been effective at ensuring the recommendation had been complied with. We were informed by the provider after the inspection that they had reviewed the records of temperatures and felt that as the temperature had not been over 25 degrees for seven days or more in a row this would not affect the medicines. Air conditioning units had been purchased by the provider after the inspection to address the temperature issue. The provider had identified some concerns through their own quality assurance processes however they were not effectively monitored as the concerns had not been acted on.

Feedback from people, relatives and other relevant persons had not always been used to make improvements to the service. Although regular meetings took place with people and their relatives staff had not always implemented changes to make improvements. The meeting in February 2018 recorded that one relative raised a concern around the laundry as other people's clothing was found in their family members room. This was also raised by people on the day of our inspection, demonstrating that any action taken had not yet been effective at addressing the issues. In March 2018 the Anchor dementia advisor joined the staff meeting and explained to care staff how important it was to keep the care files up to date. However during this inspection we found a number of issues with the quality of records at the home. The February 2018 meeting gave key workers an exercise to write about the people they looked after. This highlighted some

shortfalls in staff knowledge, and staff were asked to re-read the peoples care plans. These plans were not always updated to reflect the current needs of people. Completion of records was an ongoing improvement activity that the manager and senior managers were monitoring at the time of our inspection.

Failure to have consistent management and robust management oversight of the home to ensure continuous improvement was a breach in Regulation 17 (Good Governance) of the Health and Social Care Act 2008 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were involved in how the service was run and improving it. Regular staff meetings took place to share information and ask for ideas and suggestions. The meetings were also used to discuss emerging issues identified form internal audits, or feedback from people and visitors. The meetings had taken place each month in 2018 and covered topics such as the importance of hydration and how staff would be supporting people with this, changes in staffing as well as giving people the chance to feedback any other business. Learning from errors and sharing what the staff had done to address complaints had also been discussed. This included talking about two complaints that had been made, and how staff practice had changed as a result. They also talked about activities, such as how these would be managed in the absence of the activities coordinators. The chef attended some of the meetings to get feedback from people on the menu, and ask for suggestions or changes that people may wish to make. The last meeting recorded that everyone who attended was happy with the menu.

Staff also felt supported by the new manager. One staff member said, "Management are very good and approachable. The staff are friendly." Another staff member said, "The new manager employed me and is very supportive. The support is amazing."

The manager was aware of their responsibilities with regards to reporting significant events to the Care Quality Commission and other outside agencies. This meant we could check that appropriate action had been taken.

The staff worked in partnership working with other agencies to learn and implement new ideas. They used these partnerships to evolve and improve the home for people. They had visits from a dietician to look at best practice around provision of food to people in the home and how to meet their individual needs. They were working with the local authority on the introduction of the 'Red Bag' system. This is an initiative where by each person has a bag that contains all the information other agencies would need if the person had to leave the home in an emergency. It also contained personal items for the person such as toothbrush, hair brush and anything else important to the individual to enable them to feel at home as much as possible. Staff at Ridgemount were also working with the local authority on improving hydration within the home. This had resulted in hydration stations being set up in the units to encourage people to drink more fluids.

Management were keen to learn and improve and ensure the staff met people needs. The manager explained, "It is clear to me that in some areas, we have fallen behind other Anchor homes. One example is where we have fallen behind on the area of engagement and community involvement. I want to get Ridgemount back into the community and have a plan to get this done by the end of the year." They went on to say, "I have identified that we have had a bit of disengagement with relatives, I don't know whether it's because they are happy with what we are doing, or they are just apathetic (feeling detached, and uninterested). We used to have relatives be more involved in the home, such as volunteering, and this is something I want to bring back." The manager and senior managers had a clear vision for how they wanted the home, and the improvements that were required so that they could better met people's needs.

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 9 HSCA RA Regulations 2014 Person-centred care<br><br>People's care and treatment did not always meet their needs nor reflect their preferences. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>Failure to do all that was reasonable practicable to mitigate risks to people's health and safety and the failure to manage peoples medicines. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints<br><br>The system for receiving, recording and handling complaints had not been effective at ensuring all complaints were investigated. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>Failure to have consistent management and robust management oversight of the home to ensure continuous improvement. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or | Regulation 18 HSCA RA Regulations 2014 Staffing |

| | |
|---|---|
| personal care | The provider had failed to deploy sufficient numbers of staff at all times to meet people's needs |