Ripon Care Limited

The Moors Care Centre

Inspection report

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Date of inspection visit:
05 October 2017

Date of publication:
15 January 2018

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 5 October 2017 and was unannounced.

The Moors Care Centre is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection

The Moors Care Centre accommodates 70 people, including older people and people over the age of 18, who may be living with dementia, mental health problems, physical disabilities or sensory impairment. At the time of our inspection there were 58 people who used the service. The building has a basement floor containing utility facilities and a cinema. There are a further three floors offering single room accommodation to people who used the service. The top three floors all have various communal spaces including lounges and dining rooms. The ground floor level also has a café facility and a hairdressing salon.

We carried out an unannounced comprehensive inspection of this service on 2 May 2017. After that inspection we received concerns in relation to the care of a person who used the service. The concerns raised included allegations of abuse, poor care and poor management of the service. As a result we undertook a focused inspection to look into these concerns. This report only covers our findings in relation to the key questions of: is the service safe, is the service caring and is the service well-led? You can read the report from our last comprehensive inspection by selecting the 'all reports' link for (The Moors Care Centre) on our website at www.cqc.org.uk

The provider is required to have a registered manager for the service and at the time of our inspection there was 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. The registered manager was not at the service for this inspection. The deputy manager assisted us throughout the inspection.

Safeguarding policy and procedures were in place and staff had received training. We found that although the service usually reported safeguarding alerts appropriately, there were occasions where incidents had not been reported internally and to relevant external authorities / bodies including CQC.

The assessment, monitoring and mitigation of risk towards people who used the service with regard to accidents/incidents, medicine management, food and hydration, falls, oral care and pressure care was not robust. This meant people's health and safety was at potential risk of harm.

On-going internal and external investigations had shown that people were not always treated with respect and dignity and evidence had been found of poor care practices by certain staff.

The system used to determine the number of staff and range of skills needed to meet the needs of the people who used the service and keep them safe at all times was not effective. Staffing levels and skill mix had not been reviewed consistently. We asked the provider to send us an up to date review, which they did in the agreed timescale. Staff recruitment was carried out safely.

Care files were completed in an inconsistent manner, with some documentation not being completed and care plans not always up to date. This meant staff did not always have appropriate records to show how they were meeting people's needs. However, people who spoke with us said they felt safe and well cared for. They took part in activities and had access to church services.

The provider's complaints policy and procedure was not being followed consistently. Some relatives felt their concerns were being ignored or not answered robustly.

The management within the service did not effectively operate the quality assurance systems that were in place. Audits completed by the registered manager showed there were a number of recognised concerns with regard to documentation and people's health and well-being. However, insufficient action had been taken to mitigate these known risks.

Most staff supervisions were carried out as a group which did not give staff opportunity to speak to the management team in a confidential way about any concerns they may have. Meetings for staff and people who used the service were not held regularly and this limited people's opportunities to feed back their opinions and views of the service.

The shortfalls identified at this inspection in the monitoring and oversight of the service meant that at least one vulnerable person had experienced unacceptable standards of care from several members of staff. Inadequate monitoring of the service and the person in day-to-day charge had created risks to the health, safety and welfare of people who were receiving a service.

We saw that people received their medicines in a safe way.

We have found a breach of Regulation 12: Safe care and treatment; Regulation 10: Dignity and Respect and Regulation 17: Good governance during this inspection. You can see what action we told the provider to take at the back 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.

The monitoring, review and mitigation of risk for people who used the service was ineffective. The reporting of safeguarding alerts was not consistently carried out.

The review of staffing levels and skill mix was not robust, but recruitment of staff was completed safely.

Medicines were managed safely and people received them as prescribed.

Is the service caring?

Requires Improvement

The service was not always caring.

People were not always treated with respect and dignity and we found evidence of poor care practices by certain staff.

People who spoke with us said the staff were kind and they were happy in the service. They had a range of activities to take part in which they enjoyed and had access to church services.

Is the service well-led?

Inadequate

The service was not well-led.

Quality assurance systems were not operated effectively and the monitoring and mitigation of risk was not robust. Reporting of abuse, accidents and incidents was not carried out consistently.

Records of care were not consistently maintained, which meant people's needs were potentially at risk of not being met.

The registered manager's response to and their overview of concerns and complaints was poor and relatives felt their concerns had been ignored or not answered robustly.

There was a lack of support for staff in that supervisions and staff meetings were not effective in enabling staff to voice their opinions and views of the service.	

The Moors Care Centre

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 The Moors Care Centre on 5 October 2017. This inspection was prompted by the notification of an allegation of abuse in relation to the care and treatment of a person who used the service. This allegation is subject to an investigation by the North Yorkshire County Council safeguarding team and as a result this inspection did not examine the circumstances of the incident.

However, the information shared with CQC about the safeguarding alert indicated potential concerns about the management of risk of: unsafe and poor care practices, unsafe recruitment, under reporting of accidents and incidents, unsafe staffing levels, unsafe handling and documentation of complaints. This inspection examined those risks.

The inspection team consisted of three inspectors. The team inspected the service against three of the five questions we ask about services: is the service safe, is the service caring and is the service well-led? No risks, concerns or significant improvement were identified in the remaining key questions through our on-going 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.

During our inspection, we spoke with the provider's nominated individual, the deputy manager and two members of staff. We also spoke with two relatives and four people who used the service. We used the Short Observational Framework Tool for inspection (SOFI). SOFI is a way of observing care to help understand the experience of people who could not talk with us. We observed staff interacting with people who used the service and the level of support provided to people throughout the day.

We looked at six people's care records, including their initial assessments, care plans, reviews, risk

assessments and medication administration records (MARs). We also looked at a selection of documentation pertaining to the management and running of the service. This included quality assurance information, audits, stakeholder surveys, recruitment information for three members of staff, staff supervision records, policies and procedures and records of maintenance carried out on equipment.

Requires Improvement

Is the service safe?

Our findings

We found evidence during our inspection that indicated incidents that affected the health, safety and welfare of people who used the service had not always been reported internally and to relevant external authorities / bodies including CQC.

We found examples where staff had witnessed abuse but had not followed safeguarding procedures. For example, staff had witnessed one incident and made a record of this in the accidents and incident file. They then reported this concern to the registered manager the following morning. However, the registered manager had failed to report this to the local authority safeguarding team and CQC.

Over the last year we have received eight safeguarding notifications of other appropriately referred incidents. Discussion with the nominated individual indicated they were checking through their files to ensure no other notifications had been missed. We were assured that more robust oversight would be maintained.

Accident and incidents had been recorded and monitored by the registered manager. However, where concerns had been noted around trends and patterns the registered manager and provider had failed to take action to mitigate risk to people who used the service.

For example, from May to August 2017 we identified there had been a high number of falls at night on one of the units within the service. The registered manager had noted this as a 'high alert' in July 2017 with recurrent falls taking place within two specific time frames. However, there was no evidence that the registered manager or provider had taken any action to investigate this further or mitigate the risk to prevent further accidents on this unit taking place.

We noted that on at least four occasions the accident records stated that sensor mats were not plugged in or were faulty. We looked at the provider visit reports for the last six months and saw that these indicated that all accidents and incidents had been dealt with appropriately. When we asked the nominated individual about this they said they relied on the registered manager to inform them of any issues. We asked the provider to improve their oversight procedures for the number of falls taking place. We also asked them to ensure the sensor equipment was used appropriately by staff and checked by the maintenance team on a regular basis.

We noted that incidents were not learnt from and used to prevent their future reoccurrence. For example one person had accidents recorded in August and October 2017 where staff had caused skin tears to the person's legs whilst hoisting. This person's risk assessments clearly showed they were at high risk of damage in relation to skin integrity and were receiving wound care to two areas on their body at the time of our inspection. The failure of staff to take extreme care when moving this person resulted in them receiving injuries which required on-going medical treatment. We discussed this with the nominated individual who said they were not aware of this. We asked the provider to improve their oversight of incidents and ensure staff practice was monitored and reviewed regularly.

The above evidence showed this was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Medicine records were on an electronic system and the medicine administration records (MARs) we checked were completed appropriately. There were appropriate arrangements in place for the management of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse); they were stored in a controlled drugs cupboard, access to them was restricted and the keys held securely.

We spoke with staff about working within the service and one member of staff said, "I love my job, the people I look after are lovely." However, staff said that in relation to staffing levels they felt that more staff would be beneficial on a morning. We were told, "There are three staff on the unit today, but we are supporting two people who both need two care staff to meet their physical needs." We looked at the dependency tool used to estimate staffing levels and saw this was not being used effectively as it had not been reviewed on a regular basis. This meant the level of people's needs might not have been met by the number of staff on duty. We asked the service to update the tool as soon as possible and send us the revised copy of dependencies and staffing levels by Monday 9 October 2017. The provider complied with this request.

During this inspection people who used the service told us they felt happy and safe there. We were told, "I feel safe and well looked after" and "Yes, I feel safe. The care staff are super, they come quickly when I use my call bell."

Risk assessments in people's care files had been completed and contained sufficient detail which enabled staff to support people safely. For example, a falls risk assessment had been developed for a person who had suffered an increased number of falls. This provided staff with details such as ensuring the person was wearing appropriate footwear and had mobility aids to hand. We saw risk assessments had been updated when changes occurred so they contained the most up to date information.

During the inspection, we looked at four staff recruitment files. We could see from the records we looked at that safe recruitment procedures were followed. Applications and interviews had been completed. Two checked references and a Disclosure and Barring Service (DBS) check had been sought prior to staff starting employment at the service. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with vulnerable adults. This helps employers make safer recruiting decisions and also minimises the risk of unsuitable people working with adults at risk.

During the morning of our inspection, we walked around the building. The environment was clean and tidy and there were no malodours. There were contingency arrangements in place so that staff knew what to do and who to contact in the event of an emergency. The fire risk assessment for the service was up to date and reviewed regularly. Gas, water, fire and electrical systems were regularly checked, serviced at appropriate intervals and repaired when required.

Requires Improvement

Is the service caring?

Our findings

The information gathered by us as part of our inspection planning included the viewing of video footage taken, by a relative, within the service. This clearly showed people were not always treated with dignity and respect. The footage highlighted examples of poor care practice from a number of staff, which included staff compromising people's dignity and staff not interacting with people whilst providing personal care. The provider followed their disciplinary process for the staff involved and they were dismissed from the service and referred to the DBS and professional bodies such as the Nursing and Midwifery Council.

Following the inspection day at the service we received further information from the provider that two other staff had been disciplined and dismissed. One incident was with regard to not following professional advice from the dietician and speech and language team (SALT), about diets for people with swallowing difficulties. The other incident was in relation to a member of staff's behaviour towards a person who used the service.

People should always be treated with dignity and respect at all times and without discrimination. The registered manager and staff did not challenge behaviour and practices that fell short of this.

The above evidence showed this was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

During the inspection, we carried out an observation exercise [SOFI] and saw positive interactions between people and staff. Staff were seen to take an interest in how people were spending their day. For example, one person had spent the morning in the library on the Eskdale unit. On several occasions we saw staff interacted with this person, asked them about the books they had chosen to read and if they had enjoyed it. They also assisted the person to choose other books that may be of interest.

We received positive feedback from one relative who told us, "The staff are always very kind. Our family visit weekly and we are very happy with the service." Relatives told us that they had good communication with staff and they knew what was going on in the service. They said, "There is a newsletter and activity timetables around the service." One relative told us, "I know all the staff by their Christian name and they know me by mine. I prefer that. It is more friendly. I know they keep an eye on [Name of person who used the service] and they do regular checks on them. When I come here they always know where [Name] is. They will tell me '[Name] is in the lounge or in the library.' They always knock on doors and if they are busy helping [Name] with personal care they let me know so I don't walk in on them."

We saw staff offering people choice and listening to their responses. For example, one member of staff asked if they could change a person's shoes saying, "Those you have on are looking a bit tight." When the person agreed the staff member came back with two choices of shoe and the person chose which one they would like to wear. We observed staff showing people the different lunch options and when one person declined both and the offer of alternatives, the member of staff asked if they wanted an omelette. When the person was not sure what this was the member of staff spent time explaining this to them. The person then decided to have the omelette and enjoyed it.

We saw people taking part in chair aerobics, which they clearly enjoyed as they partook in the exercises and were smiling and laughing. There were two activity co-ordinators who supported people who used the service. For people on the specialist dementia suites, memory boxes were completed and the deputy manager spoke with enthusiasm about the interesting lives the people had led. We observed staff practice and saw they were patient, kind and caring with people. They talked through moving and handling processes with people and gave the people living with dementia reassurance. We saw staff took time to listen to people.

Inadequate

Is the service well-led?

Our findings

We looked at the processes and systems which should be in place to ensure good governance. Good governance is the way the provider uses information to make the best decisions about providing a safe and high quality service for people. Evidence gathered throughout the inspection identified a clear lack of effective systems and processes to support any formal auditing and monitoring of the service. We found a lack of analysis and identification of patterns or trends with regard to complaints, incidents such as falls and staff supervision. Records and care plans were not completed appropriately.

There was a registered manager in post. However, they were not at the service during this inspection. The deputy manager was covering this position and assisted us throughout the inspection as did the nominated individual.

We looked at the record of complaints and could see these had not always been managed appropriately by the registered manager. Records showed that complaints had been acknowledged and responded to within required timescales. However, they did not consistently acknowledge all the concerns that had been raised. We found one complaint that had been raised in May 2017 that was still unresolved. These shortfalls had not been identified by the provider as part of their own arrangements for governance checks of the service. We discussed this with the nominated individual who told us they were now managing this complaint to ensure it was resolved.

Most of the people we spoke with felt the management team responded to their concerns and that they were approachable. However, this was not consistent and we found two examples when the registered manager had failed to act on concerns to ensure high quality care was being delivered. One relative had commented, "I have lost all confidence in you [Registered manager's name]." Another relative told us that concerns they had raised with the registered manager had not been investigated or addressed. We identified that these concerns had not been brought to the attention of the provider and the nominated individual told us they had not picked up on this during their visits to the service.

Staff had been supported within their roles through regular supervisions. However, supervisions had been conducted on a group basis and did not provide staff with the opportunities to discuss concerns one-to-one with management. The supervision sessions had not focused on individual members of staff or their specific training and development needs. Team leaders were not given the opportunity to feedback to the management team any concerns that had been raised with them. This had resulted in concerns not being addressed appropriately. When we asked the nominated individual about this approach to supervision they told us the supervision process was being reviewed and would include more one-to-one sessions in the future.

Audits had been carried out by the registered manager, but these were not robust and did not always reflect what was happening in the service. We saw the audits did not evidence which member of staffs' practice needed to improve and did not identify if or when action had been taken to resolve the issues. For example, in August 2017 the care file audit identified issues in all areas looked at and checked, but the registered

manager had not written an action plan or evidenced that any action had been taken to improve documentation. The medicines audit completed in August 2017 noted a number of issues against the areas looked at, but no member of staff was identified as making the errors and there was no record of any action being taken to improve working practice. This indicated the audits did not effectively monitor, identify and mitigate risks to people who used the service. When we looked for evidence of provider oversight into these matters and the systems they operated to oversee and monitor the actions of the registered manager we found the provider oversight was not effective as it had not identified problems within the service.

Although regular meetings were held for heads of departments, with the last one recorded in August 2017, we saw that other meetings for care staff and residents were not regular with the last one recorded in May 2017. This meant that this opportunity for people and staff to voice their opinions and views of the service to the management team was not regularly explored.

We looked at six people's care records and care plans and saw that improvements were needed to ensure these were up to date and accurate. For example, one person had fallen three times in August 2017. The accident records had been completed but their falls record had not. We saw that food and fluid charts were in place, but these had not been consistently completed. In another person's file we saw that an oral assessment had been completed which said the person could refuse to remove their dentures for cleaning. This was discussed and confirmed with staff. However, there was no corresponding care plan for oral care on the electronic care file system. One person's care plan for tissue viability stated that the district nursing team had input to their wound care, but the nurse on duty said it was their responsibility. We questioned this with the deputy manager and found that the person had moved from residential to nursing care, but their care plan had not been updated.

Inspectors asked the nominated individual to account for the shortfalls identified at this inspection. They stated they had relied on the registered manager's skills and knowledge to assess and evaluate the quality of the service they provided. They told us they spoke with the registered manager on the phone and when they visited the service. However, none of these discussions or actions were recorded in any format which could be referred to for progression and improvement. This meant there was no consistent, effective oversight or monitoring to ensure an improving service which was person centred, open and inclusive.

It was established from the evidence obtained throughout this inspection process that at least one vulnerable person had experienced unacceptable standards of care from several members of staff. While poor and unsafe practices had been hidden from the provider it was clear that inadequate monitoring of the service and the person in day-to-day charge had created risks to the health, safety and welfare of people who were receiving a service.

The above evidence showed this was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider failed to ensure that when people received care and treatment, all staff treated them with dignity and respect at all times. Regulation 10 (1)(2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Care was being delivered in ways that exposed service users to significant risks to their health, safety and welfare. Reasonable and practicable action was not being taken to mitigate those risks. Regulation 12 (1) (2) (a) (b) (c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance A lack of effective governance and oversight within the service meant effective systems and processes to assess and monitor the compliance of the service were not in place. The provider failed to assess, monitor and mitigate risk to the health, safety and welfare of service users and failed to maintain accurate and complete records in respect of each service

user.

Regulation 17(1) (2)