Moorlands Holdings (N.E.) Limited

Ravensmount Residential Care Home

Inspection report

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Ratings

Overall rating for this service	**Inadequate**
Is the service safe?	**Inadequate**
Is the service effective?	**Requires improvement**
Is the service caring?	
Is the service responsive?	**Requires improvement**
Is the service well-led?	**Inadequate**

Overall summary

This inspection took place 11 May 2015 and was unannounced. We carried out the inspection because concerns had been raised through a safeguarding alert about staffing at the home. We also checked on progress the provider had made in relation to action plans they had sent us following our inspection in January 2015, when we found continued breaches of regulations and had found the service inadequate. This inspection was to assess how the provider had responded to our concerns.

Ravensmount Residential Care Home is registered to provide accommodation for up to 30 people. At the time of the inspection there were nine people using the service, some of whom were living with dementia.

The home has not had a manager registered since May 2014. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered

Summary of findings

persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the service is run.

We found there were continuing breaches of regulations in relation to the maintenance of the premises and the cleanliness of the home. Gas supplies to the home's kitchens had been disconnected in January 2015 due to concerns over the safety of the system. A key pad lock remained broken affecting the security of the building and allowing unmonitored access to the home. One unused room remained unsecured and had no handle on the inside of the door, meaning people could inadvertently become trapped in the room. Window restrictors had been fitted to some windows, although the devices used did not meet the requirements for care homes as set out by the Health and Safety Executive. Other windows still had door chains fitted as restrictors, although fittings had been moved to make them more difficult to open. Some fire doors were broken meaning they did not shut into the recess of the door frame correctly to make a smoke tight seal. Some work had been undertaken as to the maintenance of the outside of the building with some ground floor windows painted.

The home was superficially clean, although some bedrooms had dust and crumbs in them. Domestic staff told us they had returned to splitting their working hours between cleaning tasks and working in the kitchen. This meant the time dedicated to cleaning at the home had reduced to 31 hours per week. They told us that with the current hours they found it difficult to deep clean individual rooms. The provider told us he had changed the rota system for domestic and kitchen staff to ensure staff were available from 8.00am until 6.00pm.

We noted an infection control audit had been untaken in January 2015. However, this was largely tick box and where there were items ticked as not being in place, there was no indication what action had been taken. The provider told us they had met with the commissioners and infection control staff and had agreed an action plan. He said he would forward this plan to us.

We found the majority of lifting equipment had been checked and safety certificates were now in place. Weighing scales had been omitted from these checks and the provider told us this had been an oversight. People said there were enough staff at the home and we observed there was a good ratio of staff to people living at the home. We checked staffing rotas and saw there was generally three staff on day shifts and two at night. The provider agreed that cover by senior care staff had been an issue in recent months but was being managed, including the use of agency staff.

Staff told us they had undertaken some training in the months since the previous inspection, although senior staff told us they had not received any formal training on the safe handling of medicines since 2011.

CQC monitors the operation of the Deprivation of Liberty Safeguards (DoLS). DoLS are part of the Mental Capacity Act 2005. These safeguards aim to make sure people are looked after in a way that does not inappropriately restrict their freedom. The provider told us that all people living at the home had now been assessed in relation to whether they had their freedom restricted, as defined by the Mental Capacity Act (2005) and the DoLS guidance. We checked with the local authority safeguarding adults team, who confirmed reviews were in progress.

We found care records had not been reviewed or updated since February 2015 and in some cases there were two sets of care plans in place for each element of people's care; meaning it was not clear what action should be taken to support people. We found one person's diabetic medicine's had been changed but this had not been updated in their care plan.

We found there were continuing breaches of regulations in relation to quality monitoring at the home. Quality monitoring documents remained limited in their content and did not contain any action plans or dates for work to be completed by. The provider showed us a document concerning 'walk round' audits of the home which merely stated the home was clean and tidy. The audits process had failed to note the broken lock and fire risks highlighted during the inspection. Audits of care plans were also not recorded as taking place since February 2015. Some review of incidents and accidents had been undertaken, but this was limited.

We had previously found six breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. At this inspection we found continuing concerns which constituted a breach of three regulations under the

Summary of findings

new Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 which came into force on the 1 April 2015. These related to safe care and treatment, good governance and staffing.

We have judged that the continued breach of regulations by the provider has had or may have a major impact on people. We have taken enforcement action against the provider and have issued a Notice of Decision to confirm the removal of the location Ravensmount Residential Care Home from their registration.

Summary of findings

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.

We found there were continuing issues with safety at the home. Some fire doors were broken and did not fit correctly to form a seal against smoke. A keypad lock remained broken allowing unrestricted access to the home. Window restrictors had been fitted; however, they did not meet the requirements of the Health and Safety Executive in relation to safety in care homes.

The cleanliness of the home was adequate, although some individual rooms were dusty and had crumbs on the floor. Domestic provision at the home had been reduced from 41to 31 hours per week and staff told us they struggled to maintain effective cleaning at the home. No legionella risk assessment had been undertaken at the home.

Some work had been carried out on the ground floor of the outside of the premises with window frames repainted.

Is the service effective?

Requires improvement

The service was not always effective.

We found that a number of areas of staff training had been undertaken since the last inspection. However, staff told us, and records showed that formal training on the safe handling of medicines had not taken place since 2011.

Mental Capacity Act (2005) assessments had been undertaken to determine if people required applications to the local safeguarding adults team to determine if people needed their freedom restricted as defined by the Deprivation of Liberty Safeguards. The local authority safeguarding adults team confirmed applications were in place.

Is the service caring?

We did not review this domain because we rated it as good at our previous inspection.

Is the service responsive?

Requires improvement

The service was not always responsive.

Care plans were not always reviewed and updated as people's needs changed. Some care records contained duplicate care plans, so it was not clear what action staff should take to support people's needs. A change in one person's medicines to support their diabetes had not been updated in their care records.

Summary of findings

Is the service well-led?

Inadequate

The service was not well led.

The home continued to operate without a registered manager in post and had done so since May 2014.

Audits of the home remained limited in depth and had failed to identify health and safety issues, such as a broken keypad and broken fire doors.

Audits on care plans had not been undertaken since February 2015.

Ravensmount Residential Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was undertaken to check the home was operating safely following concerns raised with us with regard to staffing. The inspection also followed up on the provider's own action plans, from our previous inspection, to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

This inspection took place on 11 May 2015 and was unannounced.

The inspection team consisted of two inspectors.

We reviewed information we held about the home. We contacted the local authority contracts team and the local authority safeguarding adults team to ascertain information they held about the home. We used their comments to support our planning of the inspection.

We spoke with three people who used the service to obtain their views on the care and support they received. We talked with the provider's representative, two senior care workers, the cook and a member of the housekeeping team.

We reviewed a range of documents and records including; three care records for people who used the service, five medicine administration records (MARs), duty rotas, accidents and incident records and a range of other quality audits and management records presented to us by the provider.

Inadequate

Is the service safe?

Our findings

At our previous inspection we were told that estimates had been obtained from a company regarding the leasing of a new gas cooker for the home. At this inspection we found all gas supplies to the home's kitchen had been cut off and capped in January 2015. This was by a gas engineer who had found serious concerns with the gas supply and ventilation system in the kitchen area. These concerns were identified as being immediately dangerous. Particular concerns related to the extraction and ventilation system not being adequate, with carbon dioxide readings in the kitchen above the permitted level. We also noted further concerns were detailed about safety systems and shut off valves for the gas system. We spoke with the gas engineer who had carried out the inspection, who confirmed that appliances and systems had been in a dangerous state, but had been made safe and would remain safe whilst the gas system was disconnected and capped off. He told us the state of the system had required him to make a report to the Health and Safety Executive (HSE) under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR). He forwarded us a copy of this report.

Our records show we had raised concerns with the provider about the gas cooker and ventilation system in the kitchen area, following our inspection in August 2014. We received written assurances, via email, that the ventilation system in the kitchen was fully operational and that work on the cooker had been carried out to a satisfactory standard.

The current situation meant the home had been without a catering standard cooker and a 'hot box', used to keep food warm between cooking and serving, from 9 January 2015 onwards. We saw the provider had installed a domestic electric cooker in the kitchen along with a surface top fryer. This meant people had access to hot food. We asked the cook if she had access to the equipment required to properly provide meals for people living at the home. The cook told us that although she coped with the equipment provided it was not ideal, particularly the loss of the hot box.

We asked the provider what action had been taken with regard to a replacement cooker and the work required in the kitchen area. He told us he had not taken any further action as a potential new provider was intending to lease new equipment in the future and work would be undertaken at this point.

We had also raised concerns about the upkeep of the exterior of the building. We noted at this inspection that some window frames on the ground floor of the building had been painted. However, the majority of the building remained in need of repair. The provider told us that scaffolding was due to be erected in the following two days, allowing further work to be carried out across the whole of the exterior of the home. We saw a number of areas of guttering continued to be overgrown with grass and mature plants. The provider told us the guttering had been recently cleaned but the plants had regrown.

At the previous inspection we had found door chains had been fitted to act as window restrictors for a number of windows, allowing them to be opened wide and present a fall hazard. We saw at this inspection the provider had fitted window restrictors, which did comply with British Standards, to most windows in individual rooms. However, these restrictors did not comply with HSE advice on the use of window restrictors in care homes. HSE guidance on the use of window restrictors states these should; "Be robustly secured using tamper-proof fittings so they cannot be removed or disengaged using readily accessible implements (such as cutlery) and require a special tool or key." The guidance also states; "that 'safety restricted hinges' that limit the initial opening of a window can be overridden without the use of any tools and are not suitable in health and social care premises where individuals are identified as being vulnerable to the risk of falls from windows."

We found other windows still had door chains fitted to restrict their opening, although saw that fittings had been moved to prevent chains being disengaged. However, a window in a linen cupboard area, where the door lock was broken allowing open access, still had a door chain fitted which could be disengaged.

We found one vacant room was unlocked because there was no door handle or lock fitted. We saw on entering the room there was no door handle on the inside. We found when the door was closed it was difficult to open it from the inside because of the missing handle. This meant that people, who were potentially confused or distressed, could become inadvertently trapped in the room. We further

Is the service safe?

found a keypad lock we had previously noted to be broken, allowing unrestricted access to the home and compromising the safety of people and staff, was again not working. This meant the safety and security of people living at the home continued to be put at risk. The provider told us he understood the matter had been addressed and would arrange for work to be carried out again.

Additionally, we found fire doors did not fit into the recess of the door frames and therefore did not form an effective seal against smoke and heat, in the event of a fire. One door led from a stairway to a corridor on the top floor. Another concerned the linen room on the top floor. This room was unlocked, with the door open and contained a range of highly combustible material. In a third location, a door to a cupboard at the bottom of a stairwell, which was a fire escape route, was broken and could not be closed. The cupboard had a range of combustible materials stored in it. We spoke with the provider about these issues. He told us he was not aware of the situation and agreed to have matters rectified as soon as possible. The provider and his contractor subsequently emailed us to say that work on these areas had either been completed or was being addressed.

We examined the emergency lighting at the home and found all units were now working. We also saw weekly fire alarm tests were carried out. However, we noted there had been no fire evacuation practices at the home since January 2015. Hoists and electrical baths had up to date Lifting Operations and Lifting Equipment Regulations (LOLER) certificates. The weighing scales used at the home did not have a LOLER certificate. The provider told us this had been an omission when all the other items had been tested.

At the time of our previous inspection these issues constituted a breach of Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010. (Safety and suitability of premises) and Regulation 16 HSCA 2008 (Regulated Activities) Regulations 2010. (Safety, availability and suitability of equipment). Our findings at this inspection constitute a breach of Regulation 12(d)(e) HSCA 2008 (Regulated Activities) Regulations 2014 (Safe care and treatment) under the regulations that came into force on 1 April 2015. We have referred our findings to the local authority public safety team and the local fire service.

At the time of our inspections in August 2014 and January 2015 we expressed concerns about cleanliness and infection control at the home. At the last inspection we noted there were two members of staff, dedicated to cleaning at the home, working a total of 41 hours per week. We found cleanliness at the home had much improved at that time.

At this inspection the home was superficially clean, although some bedrooms had dust and crumbs in them. Domestic staff told us they had returned to splitting their working hours between cleaning tasks and working in the kitchen. They said in a morning they worked one hour in the kitchen and three hours on cleaning duties. On an afternoon shift a staff member worked for two hours cleaning and two hours in the kitchen. On an afternoon shift they were the only person working in the kitchen. At the weekend the shift consisted of two hours working in the kitchen and three hours cleaning. This meant the time dedicated to cleaning at the home had reduced to 31 hours per week.

Staff also told us that under the old system there were at least two days a week where two domestic staff worked together, allowing them to deep clean rooms on a regular basis. They told us that with the current hours they found it difficult to deep clean individual rooms and it was a struggle to keep on top of things. We spoke with the provider about domestic hours. He told us he had changed the rota system to ensure domestic and kitchen staff were available from 8.00am until 6.00pm.

We noted an infection control audit had been untaken in January 2015. However, this was largely tick box and where there were items ticked as not being in place, there was no indication as to what action had been taken. Before the inspection we had spoken to the local authority commissioners who had told us a recent infection control visit had raised a number of issues. The provider told us they had met with the commissioners and infection control staff and had agreed an action plan. He said he would forward this plan to us. He said that as part of the plan badly worn vinyl in the dining room was due to be replaced.

We found some issues with the laundry area which was in need of tidying, particularly in relation to the washer and area around the washer. We also found potentially soiled protective equipment in a basket for used towels. Staff said they thought the items were clean and had fallen into the basket; although the basket was lidded.

Inadequate

Is the service safe?

The provider's contractor told us he carried out monthly tests on water temperatures at the home, although the record file could not be found. The provider told us there was no full legionella assessment for the home. We found a hot water tank in a cupboard area adjacent to the laundry area. We saw piping from this tank was leaking and a tall waste paper bin was used to collect the dripping water. Toilet seats previously identified as stained and dirty had been replaced, although in two toilet areas the fixing of these was very loose.

At the time of our previous inspection these issues constituted a breach of Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 (Cleanliness and infection control). Our findings at this inspection constitute a breach of Regulation 12(h) HSCA 2008 (Regulated Activities) Regulations 2014 (Safe care and treatment) under the regulations that came into force on 1April 2015

One of the reasons we carried out the inspection was due to concerns being raised about staffing at the home. We found there was one senior and two care workers on duty on the day of the inspection. We looked at duty rotas for the previous three weeks at the home. We found the majority of shifts were covered by three staff, although this sometimes included night staff coming in early for shifts or staying late. The provider agreed maintaining senior carer cover had been an issue since January, due to long term sickness. He said hoped this would be resolved soon and said bank staff had also been used to cover shifts.

Since the previous inspection the provider had commenced a log of incidents and accidents. There was some review of issues related to incidents and accidents at the home, but this was limited.

Requires improvement

Is the service effective?

Our findings

At our inspection in January 2015 staff had told us their training was not fully up to date. One staff member told us their training in the safe handling of medicines was out of date. The provider had shown us a training matrix of planned training they intended to undertake with staff over the coming months.

At this inspection we found a number of training modules had been updated, with the provider and staff confirming they had recently undertaken infection control training, provided by a local infection control nurse. Staff also told us a manager, employed by the prospective future provider was undertaking a further review of training.

We noted, however, training on the safe handling of medicines had still not been updated. We spoke to a senior care worker who told us she could not recall when she last had any refresher training on medicines and that the last recorded date of 2011 was probably correct. We also noted a member of staff, who was supporting work in the kitchen, was not recorded as having any food hygiene training.

One person living at the home was recorded to be diabetic and received support from the staff in dealing with their condition. Staff told us they had received support from the visiting district nurse with regard to this support. One recently recruited senior care worker had not yet received any instruction on how to monitor this person's blood sugar levels. Staff said this was to be addressed with the district nurse. Records showed no staff had received any formal training with regard to their knowledge and management of diabetic conditions.

This constitutes a breach of Regulation 18(2)(a) HSCA 2008 (Regulated Activities) Regulations 2014 (Staffing) under the regulations that came into force on 1April 2015.

At our previous inspection we had noted no action had been taken to assess people's capacity and their ability to agree to remain living at the home under the Mental Capacity Act (2005) (MCA) and Deprivation of Liberty Safeguards (DoLS). The provider told us applications and assessments were now in progress. We confirmed the appropriate applications had been received by the local authority safeguarding adults team.

At the last inspection we had highlighted there were limited adaptations to support people at the home who were living with dementia; such as pictorial signage on toilets and bathrooms. We noted that no further action had been taken in relation to this matter.

Is the service caring?

Our findings

We did not review this domain because we rated it as good at our previous inspection.

Requires improvement

Is the service responsive?

Our findings

At our inspection undertaken in January 2015 we found people's care plans had not always been reviewed and were not always up to date. The acting manager at the time told us the home was reformatting and updating care records.

At this inspection we found care plans were again not always reviewed, were not updated and were unclear. Care records we looked at contained two sets of plans for people's care, one care plan had not been updated since November 2014, whilst a second care plan for the same area of support had not been updated since February 2015. The second care plan was also overlaid with 'post it' notes with comments such as, "More detailed action plan required" and "More detail or refer to challenging behaviour care plan" written on them. This meant it was unclear whether the plans were up to date, which care plan were current and which should be followed by staff.

Staff told us that because of the small number of residents at the home they knew people's needs well. The provider confirmed some people at the home did have two care plans because the changeover to new format care plans was still in progress from January 2015. The provider subsequently emailed us and said staff had not shown us the small number of care records that had been completed in the new format.

Care records we were shown and examined lacked detail. For example, one person required regular blood sugar checks and support in managing a urinary catheter. There was no guidance as to what steps or actions staff should take to support these needs. The care plan stated, "Staff to observe X for any signs of being unwell or having high or low blood sugar levels." However, there were no clear guidelines as to what high or low blood sugar levels would be and what signs staff should observe for.

We also found on the person's Medicine Administration Record (MAR) that the level of insulin they received in the morning had been reduced. Whilst this had been noted on the MAR we found the care record had not been updated to reflect this change. The provider confirmed this was an error and the care plan should have been updated.

At the time of our previous inspection these issues constituted a breach of Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 (Records). Our findings at this inspection constitute a breach of Regulation 17(2)(c) HSCA 2008 (Regulated Activities) Regulations 2014 (Good Governance) under the regulations which came into force on 1April 2015.

Inadequate

Is the service well-led?

Our findings

At our previous inspection in January 2015 we had raised concern that there had been no registered manager at the home since May 2014. We had told the provider this was a breach of their conditions of registration. At this inspection it was confirmed there was still no manager working at the home who was formally registered with the CQC. This meant there was no-one with day to day oversight of the home or with responsibility for the care provided.

The provider told us senior staff reported directly to him and contacted him if there were any concerns or issues. Staff we spoke with confirmed this was the case. The provider told us there had been opportunities over the last few months where he could have appointed a suitable candidate to the position of registered manager. However, because a new provider was interested in taking over the home he had felt it was unfair to do so, as the contract he would have been able to offer would have only been short term. He told us the prospective registered manager, for the possible new provider, was supporting staff on an ongoing basis and was involved in areas such as the change of care plan documents.

This meant the provider continued to operate the home in breach of their registration conditions, requiring the home to be under the supervision of a registered manager.

At the previous inspection we had raised concerns about the level of monitoring being carried out in relation to the care provided and the safety of the home. The provider told us 'walk round' checks were now being undertaken and regular monitoring was in progress. We were shown documents, written on plain paper entitled 'walk round checks.' These checks were limited in nature and consisted of statements such as, "Checked the building from top floor to bottom floor all lounges and bathroom all clean and tidy and no obstructions" and "At 18.40 I had a walk around the building from the top floor to the bottom no obstructions everywhere clean and tidy." We spoke with the provider and noted the 'walk round' audits had failed to identify the broken lock on the top floor and the broken doors presenting a fire hazard at the linen room on the top floor or the store room in the stairwell.

We were also given a document that was used to monitor care plan audits at the home. We saw there had been no entries to this document since February 2015 and this coincided with there being no reviews of care plans from this date. The current provider told us the prospective provider and future registered manager had been looking at care plans in the home. He said he would investigate why the plans had not been updated.

At the time of our previous inspection these issues constituted a breach of Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 (Quality Monitoring). Our findings at this inspection constitute a breach of Regulation 17(2)(a)(b) HSCA 2008 (Regulated Activities) Regulations 2014 (Good Governance) under the regulations that came into force on 1 April 2015.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Systems were not in place to ensure the premises and equipment used were safe or assess, prevent, detect and manage the risk of infection. Regulation 12(2)(d) (e)(h).

The enforcement action we took:
We have judged that the continued breach of regulations by the provider has had or may have a major impact on people. We have taken enforcement action against the provider and have issued a Notice of Decision to confirm the removal of the location Ravensmount Residential Care Home from their registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance Systems were not in place to monitor the quality and safety of the service and mitigate the risks relating to health and safety. Regulation 17(2)(a)(b).

The enforcement action we took:
We have judged that the continued breach of regulations by the provider has had or may have a major impact on people. We have taken enforcement action against the provider and have issued a Notice of Decision to confirm the removal of the location Ravensmount Residential Care Home from their registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing Systems were not in place to ensure staff received appropriate support and training to enable them to carry out their duties. Regulation 18(2)(a).

The enforcement action we took:
We have judged that the continued breach of regulations by the provider has had or may have a major impact on people. We have taken enforcement action against the provider and have issued a Notice of Decision to confirm the removal of the location Ravensmount Residential Care Home from their registration.