

Yorkshire Friends Housing Society Limited

Ravensworth Lodge

Inspection report

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Date of inspection visit:
13 October 2022

Date of publication:
16 February 2023

Ratings

Overall rating for this service

Requires Improvement ●

Is the service safe?

Requires Improvement ●

Is the service well-led?

Requires Improvement ●

Summary of findings

Overall summary

About the service

Ravensworth Lodge is a residential care home providing regulated activity of personal care to up to 24 people. The service provides support to older people. At the time of our inspection there were 21 people using the service.

People's experience of using this service and what we found

People did not always receive care and support to meet their assessed needs in a timely manner. Staff were working without sufficient support and guidance due to a lack of appropriate management support. Processes to ensure enough suitably trained staff were always on duty were not effective. Due to a lack of appropriate management of the service, staff did not receive appropriate checks, support and supervision to carry out their roles effectively.

The provider did not have oversight to ensure staff and health professionals had access to complete care records and up to date policies and procedures. There was no manager oversight to ensure new electronic care recording processes in place for staff to use remained effective, putting people at risk from harm. Information used to manage the risks was not robustly completed. For example, checks to keep people safe during a fire were not completed as required.

People were at risk from otherwise avoidable harm. Staff told us they were not confident in the processes in place to raise any concerns internally for further investigation. There was no clear process for staff to follow to ensure accidents, incidents and safeguarding concerns were recorded and reported as required to keep people safe. We were unable to check all required actions had been completed as the provider had failed to ensure all notifications had been submitted to the CQC as required.

There was no clear strategy in place at provider level to manage the service and no operational plan that ensured the service remained legally compliant with required regulation. The provider had failed to display CQC performance ratings both in the home and on their website. Provider oversight had failed to ensure appropriate checks were completed or reviewed to ensure systems and processes remained effective. We found a range of quality assurance audits had not been completed to check the service since January 2022.

Processes in place to ensure people lived in a clean environment and were protected from the risks of air born viruses were not robust. Where people were incontinent, insufficient numbers of staff meant people were not always assisted in a timely way as required. Deep cleaning of 3 people's carpeted rooms failed to ensure they remained free from the smell of urine and there was no plan in place to implement remedial actions for improvement.

People told us they received their medicines safely. However, checks were not completed that ensured the safe management of medicines followed best practice guidance.

People told us they felt safe and were happy with their care. Staff were knowledgeable and skilled. People received support from a range of health professionals when required. Observations and feedback confirmed the failings we found had a low impact on people at the time of the inspection, but people were at risk if continued.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

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

Rating at last inspection and update

The last rating for this service was good (published 21 March 2019).

At our last inspection we recommended the provider developed more robust systems to record and analyse accidents and incidents and improved their policy regarding medicines administration. At this inspection we found further improvements were required.

Why we inspected

We received concerns in relation to the management of the home, provider oversight, management of risks and staffing. As a result, we undertook a focused inspection to review the key questions of safe and well led only. For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service has changed from good to requires improvement based on the findings of this inspection.

We have found evidence the provider needs to make improvements. Please see the safe and well led sections of this full report.

You can see what action we have asked the provider to take at the end of this full report.

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

Enforcement and Recommendations

We have identified breaches in relation to the management of the service, provider oversight (including risk management and governance checks), quality assurance, staffing and recruitment.

We have made recommendations for the provider to review and improve their policy and practice for infection prevention and medicines control and the reporting of accidents incidents and safeguarding.

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

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up

We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not always safe.

Details are in our safe findings below.

Requires Improvement ●

Is the service well-led?

The service was not always well-led.

Details are in our well-led findings below.

Requires Improvement ●

Ravensworth Lodge

Detailed findings

Background to this inspection

The inspection

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

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

Inspection team

The inspection was carried out by one inspector and an Expert 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.

Service and service type

Ravensworth Lodge is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Ravensworth Lodge is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager

This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations. At the time of our inspection there was not a registered manager in post.

Notice of inspection

This inspection was unannounced.

What we did before the inspection

We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection

We spoke with 7 people using the service and with 11 staff members; including 8 care staff, a maintenance person, a cook, a domestic staff, and a consultant. We reviewed 3 paper copy care plans, 3 electronic care plans, and 4 staff files. We observed mealtime arrangements, the medication round and looked at records associated with accidents, incidents, risk and quality assurance processes used to check the service.

Is the service safe?

Our findings

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

At our last inspection we rated this key question requires improvement. At this inspection the rating has remained requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management; Lessons learnt

- Information about risks and safety was not always comprehensive or up to date. Systems and processes to assess, record and review risks associated with people's care and support and the environment were not always completed or reviewed to ensure remedial actions remained effective. For example, an open-door policy to the service failed to ensure people who required assistance to leave the home did so safely.
- There was limited use of systems to record, manage and report concerns about risks, safety and incidents. Staff told us the provider was transferring people's records from paper to electronic systems which were hard to use and unreliable.
- Important information about daily risks to people's safety were not always passed on or recorded for staff who needed it. Staff told us the electronic system in place to record daily notes was unreliable and due to managerial absence, no contingency to write notes was in place. We observed 21 electronic care plans had flagged up 'Must do' daily activities of care had not been completed.
- Informal checks of the building and equipment safety were completed. However, the service's approach to assessing and managing environmental and equipment-related risks was partial or inconsistent. For example, the lift required repairs which had been identified in 2017. There was no awareness of this potential risk or plan to action the required repairs.
- Risks relating to fire were not well managed. Information staff would need in the case of an emergency were not easily accessible. Staff had not all received required fire training. There was no management oversight to ensure required fire drills and evacuations were completed and recorded. Fire alarm and emergency system check forms had not been completed.
- The provider told us the fire risk assessment was due and they were looking to contact the local fire authority for a review of the home. However, there was no plan in place for this.

Systems had not been established to assess, monitor and mitigate risks to the health, safety and welfare of people using the service. This placed people at risk of harm. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

- People were at risk of harm because there was not always enough suitably trained staff on duty to meet people's changing needs all the time.
- The service had a high level of staff absence which put people at risk of harm. The use of agency staff as a contingency to maintain staff numbers was not always implemented. Staff told us the use of agency required a review. They told us there was no management oversight to direct agency staff who were deemed to be more of a hindrance than a help to staff on duty.

- People received the care and support they need, but staff told us they did not always have the time to be flexible or respond quickly to changing needs. One staff member said, "We should have 3 care staff on each morning, often we are down to 2 at a busy time which means people have to wait."
- Staff told us they regularly felt stretched without a clear direction for their role. One staff told us, "We have to provide care, support, laundry, mealtimes, and activities. Some of us have senior responsibilities as well so there are things which don't get done because we just don't have the support or the time."
- Records to determine checks were made to ensure suitable staff were recruited were both inconsistent and incomplete. For example, there was no information to determine appropriate DBS checks and other recruitment checks were always carried out as standard practice.
- There was no system in place to record and monitor staff performance and suitability. Observations of staff carrying out their roles was not recorded or recognised which put people at potential harm as a result.

The provider had failed to ensure enough numbers of suitably qualified, competent, skilled and experienced persons were always employed. This was a breach of regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

At our last inspection we recommended the provider improved their practice to ensure accurate stock levels were recorded, and to ensure protocols were in place to guide staff on when to administer medicines prescribed to be taken only 'when needed'. The provider had made improvements, but further improvements were required.

- Weekly checks on medicine stocks was completed but this was irregular along with irregular audits to determine operational compliance.
- Staff had received training in medicines management and administration but observations of staff competence with regards to people's medicines was not recorded. This put people at risk from not receiving their medicines as required.
- Medicines were not always stored appropriately. During the medicine round the trolley was moved to the reception area where it was left unsecured and accessible to others.

We recommend the provider improve their medicines management and administration practice following the latest guidance.

Preventing and controlling infection

- People were not always protected from the risks from airborne viruses. Staff understood the importance of following up to date guidance for the use of Personal Protective Equipment (PPE) to maintain good infection control practices. However, we had to prompt some staff to wear PPE when in communal areas outside people's rooms and when walking around the building.
- Staff did not always have access to up to date policies and procedures as point of reference for infection prevention and control. The provider told us their policies were under review and would be available electronically following training.
- There was a lack of management oversight to support and guide staff in their roles and to ensure they always followed best practice guidance.
- People's rooms were not always clean. Some rooms had a smell of urine due to the difficulty in maintaining old carpets and fabric chairs where people had been incontinent. A cleaning regime was in place to try and manage this but there was a lack of management oversight to ensure remedial actions were effective.

We recommend the provider reviews their practice and latest guidance to ensure infection prevention and control remains safe and effective.

Learning lessons when things go wrong

At our last inspection we recommended the provider developed more robust systems to record and analyse accidents and incidents. Some improvements had been made.

- A new process was in place to record and analyse accidents and incidents. The process included a monthly analysis to identify repeating trends with actions implemented as part of lessons learnt. Due to a lack of management oversight the process had not been completed robustly with some gaps noted.

Systems and processes to safeguard people from the risk of abuse;

- Staff understood how to protect people from the risk of abuse. However, staff told us they were wary of raising any concerns internally due to a lack of effective management and a break down in support and open communication from the provider. On staff member said, "I would not be comfortable raising my concerns with the provider, most staff would prefer to raise anonymous concerns to the CQC, that way we know they will be responded to without fear of reprisal."
- Staff told us they understood the requirement to raise their concerns. However, internal policy and procedure was not readily accessible to all staff and at the time of the inspection there was no access or availability to safeguarding information.

We recommend the provider research's best practice guidance to ensure their safeguarding policies and procedures supported staff with the required processes and accountability to raise their concerns internally.

Visiting in care homes

There were no visiting restrictions at the time of the inspection. Staff understood the requirement to follow latest guidance.

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 MCA 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.

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 Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

- We found the service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty.

Is the service well-led?

Our findings

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

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

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- The service is required to have a manager who is registered with the CQC. A manager had applied for their registration but revoked this application in August 2022. The provider was not aware of this and had failed to notify the CQC of the manager's absence or how the service would be run while they were away.

The CQC had not been notified of the absence of the manager with assurances the service would continue to be properly managed. This was a breach of Regulation 14: (Notice of absence) Care Quality Commission (Registration) Regulations 2009 (Part 4)

- The provider had failed to display the ratings following the previous inspection in the premises or on their web site.

This was a breach of Regulation 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Requirement as to display of performance assessments

- Quality assurance arrangements were not always applied consistently and were not effective. For example, important safety checks in January recorded these had not been completed by the senior responsible with no explanation provided. No further month's checks had been completed in 2022.
- Provider oversight had failed to ensure appropriate checks were completed and reviewed to ensure they remained effective. An Infection control and Audits file included provision to complete a range of quality assurance and management checks on the service, but most of these had not been completed since January 2022.
- There was no strategy in place by the provider to manage the service and no operational plan to ensure the service remains legally compliant with required regulations.

The provider had failed to assess, monitor and improve the quality of the service provided. This was a breach of regulation 17(2) (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- Where incidents and events had happened at the service, we were unable to make enquires to ensure all required actions had been taken including preventative measures as part of lessons learnt. This is because the provider had failed to notify the CQC of all incidents and events within reasonable timescales as required.

This was a breach of Regulation 18: (Notification of other incidents) Care Quality Commission (Registration) Regulations 2009 (Part 4) Regulation 18: Notification of other incidents

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- People enjoyed receiving care from staff who understood their needs and had worked with them for long time. However, staff were not always clear on their roles and responsibilities citing a lack of appropriate management structure, direction and support at provider level.
- Staff were unsure of lines of responsibility and accountability which prevented open consultation and engagement for the benefit of people. Due to long term absence of the manager there was no oversight to ensure staff remained up to date with all their required training, supervision or appraisals.
- Hard copies of required company policies were not accessible for staff to utilise in support of their roles. We were advised policies required up dating and although some were available electronically, staff did not have this awareness and confirmed they had not received training to access this or the electronic care plans on PC's.
- People were not assured their individual needs and preferences would be met because records were not complete for staff to follow. For example, the service was implementing electronic care planning. However, there was no management oversight or plan to ensure the recording of new information and the transfer of written files resulted in up to date records for people.
- During the inspection we found records were not always stored safely. For example, where a room was having a change of use, office documents were stored in a public corridor.

A failure to maintain securely an accurate, complete and contemporaneous record in respect of each person was a breach of Regulation 17(2) (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Working in partnership with others

- The service worked in partnership with a range of organisations. For example, during the inspection a GP attended to review 1 person's needs and a Tissue Viability Nurse attended to check the integrity of another person's skin to keep them safe from pressure sores. A staff member said, "Our priority is peoples care and support. Most staff are long standing and understand people's needs and what to do if they need additional support."

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	<p>Regulation 14 Registration Regulations 2009 Notifications – notices of absence</p> <p>The CQC has not been notified as required, of the absence of the manager with assurances that the service will continue to be properly managed. This was a breach of Regulation 14: (Notice of absence) Care Quality Commission (Registration) Regulations 2009 (Part 4)</p>
Accommodation for persons who require nursing or personal care	<p>Regulation 18 Registration Regulations 2009 Notifications of other incidents</p> <p>The provider had failed to notify the CQC of all incidents and events within reasonable timescales as required.</p> <p>This was a breach of Regulation 18: (Notification of other incidents) Care Quality Commission (Registration) Regulations 2009 (Part 4) Regulation 18: Notification of other incidents</p>
Accommodation for persons who require nursing or personal care	<p>Regulation 12 HSCA RA Regulations 2014 Safe care and treatment</p> <p>Systems had not been established to assess, monitor and mitigate risks to the health, safety and welfare of people using the service This placed people at risk of harm. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.</p>

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 17 HSCA RA Regulations 2014 Good governance</p> <p>The provider failed to assess, monitor and improve the quality of the service provided. This was a breach of regulation 17(2) (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.</p>
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 18 HSCA RA Regulations 2014 Staffing</p> <p>The provider had failed to ensure enough numbers of suitably qualified, competent, skilled and experienced persons were always employed. This was a breach of regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.</p>

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 20A HSCA RA Regulations 2014 Requirement as to display of performance assessments</p> <p>The provider had failed to display the ratings following the previous inspection in the premises or on their web site.</p> <p>This was a breach of regulation 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Requirement as to display of performance assessments</p>

The enforcement action we took:

Fixed Penalty Notice