Care Quality Commission

Key inspection report

Care homes for older people

Name:	Ravenhurst
Address:	21 Lickhill Road North Stourport-on-Severn Worcestershire DY13 8RU

The quality rating for this care home is:	zero star poor service

A quality rating is our assessment of how well a care home is meeting the needs of the people who use it. We give a quality rating following a full review of the service. We call this full review a 'key' inspection.

Lead inspector:	**Date:**							
Sandra Bromige	1	7	1	1	2	0	0	9

This is a review of quality of outcomes that people experience in this care home. We believe high quality care should

- Be safe
- Have the right outcomes, including clinical outcomes
- Be a good experience for the people that use it
- Help prevent illness, and promote healthy, independent living
- Be available to those who need it when they need it.

The first part of the review gives the overall quality rating for the care home:

- 3 stars - excellent
- 2 stars - good
- 1 star - adequate
- 0 star - poor

There is also a bar chart that gives a quick way of seeing the quality of care that the home provides under key areas that matter to people.

There is a summary of what we think this service does well, what they have improved on and, where it applies, what they need to do better. We use the national minimum standards to describe the outcomes that people should experience. National minimum standards are written by the Department of Health for each type of care service.

After the summary there is more detail about our findings. The following table explains what you will see under each outcome area.

Outcome area (for example Choice of home)

These are the outcomes that people staying in care homes should experience. They reflect the things that people have said are important to them:

This box tells you the outcomes that we will always inspect against when we do a key inspection.

This box tells you any additional outcomes that we may inspect against when we do a key inspection.

This is what people staying in this care home experience:

Judgement:

This box tells you our opinion of what we have looked at in this outcome area. We will say whether it is excellent, good, adequate or poor.

Evidence:

This box describes the information we used to come to our judgement.

We review the quality of the service against outcomes from the National Minimum Standards (NMS). Those standards are written by the Department of Health for each type of care service.

Copies of the National Minimum Standards – Care Homes for Older People can be found at www.dh.gov.uk or bought from The Stationery Office (TSO) PO Box 29, St Crispins, Duke Street, Norwich, NR3 1GN. Tel: 0870 600 5522. Online ordering from the Stationery Office is also available: www.tso.co.uk/bookshop

The mission of the Care Quality Commission is to make care better for people by:

- Regulating health and adult social care services to ensure quality and safety standards, drive improvement and stamp out bad practice
- Protecting the rights of people who use services, particularly the most vulnerable and those detained under the Mental Health Act 1983
- Providing accessible, trustworthy information on the quality of care and services so people can make better decisions about their care and so that commissioners and providers of services can improve services.
- Providing independent public accountability on how commissioners and providers of services are improving the quality of care and providing value for money.

Reader Information

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Information about the care home

Name of care home:	Ravenhurst
Address:	21 Lickhill Road North Stourport-on-Severn Worcestershire DY13 8RU
Telephone number:	01299825610
Fax number:	01299879341
Email address:	ravenhurst@orbit.org.uk
Provider web address:	www.heart-of-england.co.uk

Name of registered provider(s):	Heart of England Housing and Care Limited
Name of registered manager (if applicable)	
Mrs Anastasia Meredith	
Type of registration:	care home
Number of places registered:	50

Conditions of registration:		
Category(ies) :	Number of places (if applicable): Under 65	Over 65
dementia	50	0
old age, not falling within any other category	0	50
physical disability	50	0
Additional conditions:		
The maximum number of service users to be accommodated is: 50		
The registered person may provide the following categories of service only Care Home only Code PC to service users of either gender whose primary care needs on admission to the home are within the following categories Old age, not falling within any other category Code OP maximum number of places 50 Dementia Code DE maximum number of places 50 Physical Disability Code PD maximum number of places 50		

Date of last inspection								

Brief description of the care home
Ravenhurst is a Victorian house, which has been adapted and extended for its present purpose. It is situated on a level site on the outskirts of Stourport-on-Severn. (A

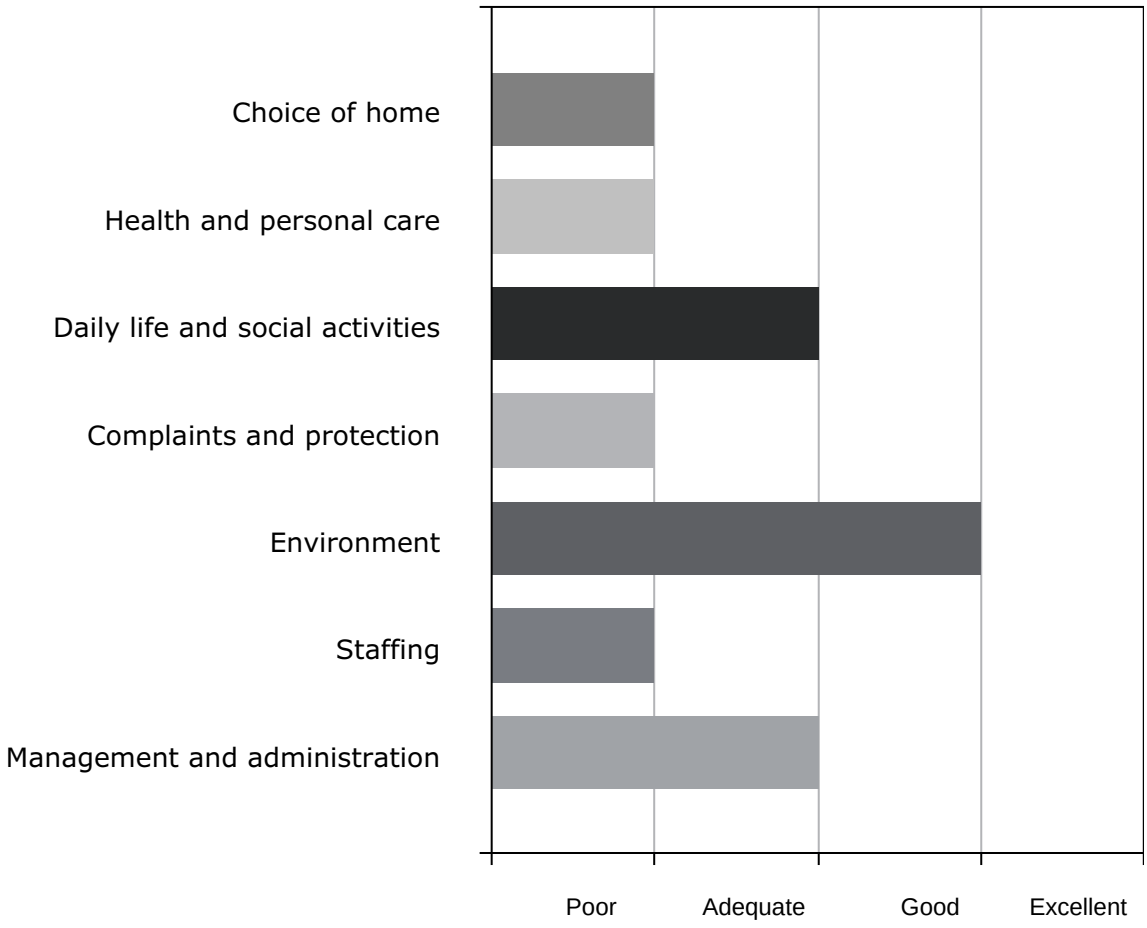
Brief description of the care home
former coach house in the grounds is used for a day care service). The home has 46 single bedrooms and two double bedrooms. Communal lounge areas, dining areas, a visitors room and communal toilets and bathrooms are also provided. There is good parking in front of the building and sheltered garden areas. The home provides residential care for older people, some of whom may have a physical disability and/or dementia. Appropriate mobility aids such as handrails, hoists and bathing aids are provided. Heart of England Housing and Care Limited owns the home and they are referred to in this report as the registered provider. The director of care, Mr John McCarthy, is the responsible individual and Mrs Meredith is the registered manager. She is supported by a hotel services manager and a deputy manager who deputise in her absence. Up-to-date information relating to the fees charged for the service is available on request from the home.

Summary

This is an overview of what we found during the inspection.

The quality rating for this care home is:	zero star poor service

Our judgement for each outcome:



How we did our inspection:

We, the commission completed the last inspection of this service on 8th December 2006.

This was an unannounced inspection. One inspector and a pharmacist inspector spent time at the home, talking to people who use the service and the staff, and looking at the records, which must be kept by the home to show that it is being run properly. The focus of our inspections is upon outcomes for people who live in the home and their views of the service provided. We looked in detail at the care provided by the home for two people and at the management of medication for ten people. This included observing the care they receive, discussing their care with staff, looking at care files and focusing on outcomes. Tracking people's care helps us understand the experiences of people who use the service. The manager of the service had previously completed an Annual Quality Assurance Assessment (AQAA). The AQAA is a self-assessment that focuses on how well outcomes are being met for people using the service. It also gives

us some numerical information about the service. Some of the manager's comments have been included within this inspection report. We also received completed survey forms from people who use the service(10), their relatives (five), and staff working at the home (six). The information from these sources helps us understand how well the home is meeting the needs of the people using the service. Some of the comments from the surveys have been included within this inspection report.

We have not received any complaints about this service in the last twelve months. We did receive a copy of the outcome of a 'stage two' investigation into a complaint in November 2008. The complaint was about poor care for an identified person and a poor standard of recording in the care records. All parts of this complaint were upheld.

One safeguarding referral has been made by the home but the outcome of this investigation is not concluded at the time of writing this report.

There has been a change of manager since the last inspection. The current manager was registered with the commission in May 2009.

What the care home does well:

The home provides information to help people decide if they wish to move in, and this information is available in large print to enable it to be accessible for people with sight difficulties, and alternative language formats for people whose first language is not English.

A variety of choice of meals are available, providing a well balanced and nutritious diet.

If people have concern with their care, they or people close to them know how to complain. Overall these concerns are looked into and action taken to put things right.

The home provides a nicely decorated and furnished, well maintained clean and comfortable environment for people to live in. Infection control is generally well managed.

Staff are caring, cheerful and very friendly and provide people with care with dignity and respect.

What has improved since the last inspection?

The home has been extended by 10 beds and parts of the home has undergone major refurbishment. This has been carried out to a good standard. The home is now registered to accommodate 50 people.

What they could do better:

Thorough assessments need to be carried out before the home decide to admit them to ensure they are able to meet their health and social care needs.

Care plans need to contain enough information and need to be reviewed when people's needs change to ensure staff understand what care is required and people can be sure their needs will be met. The home need to ensure people's healthcare needs are provided and promoted to ensure they are not at risk of neglect of care.

Significant improvement is needed to the home's management of medication, including the competency and knowledge of the staff that manage and administer medication to ensure people received their medication as prescribed and they are not placed at risk of harm.

The home need to review the provision of social care for people to ensure it is person centred and there are sufficient staff available at all times to ensure people are able to continue and enjoy their individual hobbies and interests.

Staff should ask visiting professionals to the home for their identification to ensure they maintain the safety of the people living and working in the home.

Communal laundry such as flannels and towels need to be washed at higher temperatures than at present to ensure people are not at risk of cross infection.

They need to ensure they have enough staff on duty at all times, who have the right skills and competences to meet the health and social care needs of the people who use

the service and they are not placed at risk of neglect of care.

The organisational representative needs to ensure the monthly visits to the home are unannounced and they consult people who use the service and the staff who work there to ensure people are receiving the care they need.

The management of the home needs to improve to ensure it is being run in the best interests of the people who use the service.

If you want to know what action the person responsible for this care home is taking following this report, you can contact them using the details on page 4.

The report of this inspection is available from our website www.cqc.org.uk.
You can get printed copies from enquiries@cqc.org.uk or by telephoning our order line 0870 240 7535.

Details of our findings

Contents

Choice of home

These are the outcomes that people staying in care homes should experience. They reflect the things that people have said are important to them:

People are confident that the care home can support them. This is because there is an accurate assessment of their needs that they, or people close to them, have been involved in. This tells the home all about them and the support they need. People who stay at the home only for intermediate care, have a clear assessment that includes a plan on what they hope for and want to achieve when they return home.

People can decide whether the care home can meet their support and accommodation needs. This is because they, or people close to them, have been able to visit the home and have got full, clear, accurate and up to date information about the home. If they decide to stay in the home they know about their rights and responsibilities because there is an easy to understand contract or statement of terms and conditions between them and the care home that includes how much they will pay and what the home provides for the money.

This is what people staying in this care home experience:

Judgement:

People using this service experience **poor** quality outcomes in this area. We have made this judgement using a range of evidence, including a visit to this service.

A thorough assessment is not being done prior to admission to ensure the home are able to meet the person's care needs, which places them at risk of harm.

The home does not provide intermediate care.

Evidence:

The home provides information for prospective people who may use the service. This information is also on display in the home and it contains a copy of their last inspection report. The Annual Quality Assurance Assessment (AQAA) completed by the manager prior to the inspection tells us, 'the company will provide information in native languages as appropriate - this is also evident on our website. Interpreters are provided as required. Information is provided to residents and staff in a format and language consistent with their needs'. The manager told us they are able to produce information about the home in large print and different languages. The service offers care to people who have dementia, and the service need to consider providing

Evidence:

information in an easy read format, which is more suitable for people with dementia. Sixty percent of the surveys completed by people who use the service told us they received enough information before they moved into the home.

The homes statement of purpose tells us, 'residents entering the Home must have undergone an assessment process to ensure the services within the Home can meet their individual care requirements'. The AQAA states, 'a comprehensive assessment of needs will take place prior to admission which will include an adult community assessment (if applicable) and a personal centred assessment undertaken by Ravenhurst'.

We looked at the care records of a person who has recently started using the service. There was no information to show the home had assessed this person before they moved into the home. We asked staff for the pre-admission assessment information for this person and they referred us to a document dated the day this person moved into the home. This document was poorly completed, for example the information about the medication this person takes was incomplete and the home had not checked this information with the General Practitioner to ensure they were giving it as prescribed. There was no information for staff about the type of continence equipment used to help maintain this person's dignity.

Health and personal care

These are the outcomes that people staying in care homes should experience. They reflect the things that people have said are important to them:

People's health, personal and social care needs are met. The home has a plan of care that the person, or someone close to them, has been involved in making. If they take medicine, they manage it themselves if they can. If they cannot manage their medicine, the care home supports them with it, in a safe way. People's right to privacy is respected and the support they get from staff is given in a way that maintains their dignity.
If people are approaching the end of their life, the care home will respect their choices and help them feel comfortable and secure. They, and people close to them, are reassured that their death will be handled with sensitivity, dignity and respect, and take account of their spiritual and cultural wishes.

This is what people staying in this care home experience:

Judgement:

People using this service experience **poor** quality outcomes in this area. We have made this judgement using a range of evidence, including a visit to this service.

People who use the service cannot be confident their healthcare needs will be met as the care records do not reflect their current care needs and staff are not giving consistent care which places people at risk of harm. The overall management and control of medication within the service was poor. This means that people were at risk of harm and their health and well being were not safeguarded.

Evidence:

The AQAA completed by the manager in the section 'what they do well' told us a 'full comprehensive assessment of needs is carried out. This is then used to build a care plan, which is person centred'. 'The resident and their key people have significant involvement within the care planning process'.

We case tracked the care of two people who use the service. We looked at their needs assessment and care plans and found they were poorly completed and were not person centred. For example, their was no information in either care plan to show the person who uses the service or their representative had been consulted about their plan of care. Assessment details were incomplete, for example people's weights were

Evidence:

not recorded on either assessment, one person's oral health needs and interests and hobbies information were blank. The medication people were taking was listed, but the frequency it is given was not available and there was no information to show the home had checked with the General Practitioner to ensure they were giving the medication as prescribed. The needs assessment for one person was dated and signed the day after they were admitted to the home. Neither assessment contained any information about the type and size of incontinence pads used to manage their urinary incontinence.

Care plans are not being updated as people's needs change. For example, one care plan had not been reviewed since July 2009. We saw an entry written by one of the senior care staff in the 'professional visits' section. The entry dated 2nd November showed the person was in hospital and they had gone to reassess their care needs, which is good practice. The information stated the person was not able to feed themself, was not mobile, was incontinent of urine and faeces and the home needed to refer the person to the continence adviser. The care plan had not been updated to ensure staff were aware of the changes in this person's healthcare and the home had not contacted the specialist continence nurse. We saw this person had recently been visited by the General Practitioner(GP) due to a skin rash. The GP had prescribed tablets for the rash. A lead carer told us the GP had prescribed cream for the rash and the same lead carer had administered this person's medication that morning. This shows they are giving medication to people who use the service but they do not understand what medication is prescribed for.

The care of this person's skin to prevent them from getting sore is poor. For example, the records showed the staff asked the GP for some Cavilon cream for this person for their 'red areas' of skin. The GP advised them to contact the District Nurse. We could not find any information to show the home had contacted the District Nurse. We did not see any Cavilon cream for this person. We spoke to a carer who told us this person's skin is a 'bit dry' so they use a lotion in the bath. We saw this written in the care plan and a tub of cream in the person's bedroom, although there was no label on the tub of cream. The care assistant told us they saw this person had a red bottom two days ago and they had told the lead carer. We saw their was a specialist chair cushion and mattress in this person's bedroom, but it had not been brought downstairs for use during the day. We spoke to a care assistant late afternoon and they told us the chair cushion is not brought downstairs and this person had come down for breakfast this morning and had not been back upstairs to their bedroom since.

We asked a lead carer about this person's skin condition. They told us this person

Evidence:

'should be having Cavilon cream on their bottom'. They told us they were unsure of the condition of this person's skin today. They told us this person 'should lie down after dinner on the bed', and the Propad cushion 'should be used all the time'. The care plan did not give any instructions about skin care to prevent pressure sores, and staff are not giving good and consistent care, which places this person at risk of developing pressure sores.

We saw a risk assessment for using the stairs for one person. The outcome of the risk assessment stated the person was at 'medium' risk of harm due to using the stairs, but it was not clear from the risk assessment the criteria which had been used to come to this outcome. We looked at this person's bedroom, which was on the first floor adjacent to a staircase. There was a stair gate at the top of the stairs which is secured by a latch. We saw entries in the night care plan stating this person wanders downstairs at night. There was no equipment in use such as alarm mats to ensure staff are alerted the person has come out of their bedroom and may be at risk of falling downstairs.

We saw an entry in a night care plan for another person stating they had been found on the floor in the night on the 10th November. The information showed they had a skin tear to one arm and had cut a finger. An accident form had been completed but there was no information in the care plan about the injuries to show how they were looked after and if they had now healed.

In November 2008 we received a copy of the outcome following an investigation about a serious complaint about the standard of care of a person who had used the service. The outcome upheld the elements of the complaint about pressure sores not being dealt with appropriately by care staff and poor recording in care records. We have found the same shortfalls of care during this inspection.

The pharmacist inspector visited the home on 17th November 2009 to check the management and control of medicines within the service. We looked at medication storage, some care records and medication administration records. We spoke to staff and the manager.

We saw that the available storage for medication was not adequate for the size of the home. The Lead Care office was used to store two locked medicine trolleys, a locked refrigerator and one locked medicine cupboard. We were shown another storage area, which was a small locked cupboard in a corridor. This was used to store all the extra medication on shelves. We also saw that there were many items of medication requiring return to the pharmacy stacked up on the floor space and therefore there

Evidence:

was poor access into the cupboard. We were informed that staff also use this room to store medication brought in by the pharmacy. We saw that a member of staff had to remove all of the medication for return from the cupboard and take it to another office in order to record it for collection by the pharmacy. We saw that sometimes the medication was left unattended and not secured in the office. This means that there was inadequate provision of suitable safe and secure medication storage for the number of people living in the home.

We saw a lack of organisation of medication in both medicine trolleys. We found that medication provided by the pharmacy in individual named blister packs were easy to locate, however we found it more difficult to locate medication that was available in boxes or bottles. We found these on shelves in the door of both trolleys but it took some time to find a person's named medication. We found that tablets prescribed for pain relief for named people were stored altogether in a plastic box on the bottom shelf of the trolley. This means that there was an increased risk of the wrong medication being given or medication not being located, which increases the risk of a medication error.

We found a lack of stock control and rotation of medication. For example, we saw that there were six boxes of the same medication for an identified person stored in a cupboard. The medication was an anticoagulant used to thin the blood. We saw that three boxes were dated 1st October 2009 and three boxes were dated 20th October 2009. We found that four of the boxes had been opened with tablets removed, however there was no date of opening recorded on the boxes and a lack of stock rotation. This means that it was not possible to accurately check the amount of medication that had been given to the person and there was an increased risk of a medication error.

Medication that had expired was not always returned to the pharmacy for destruction. For example, we saw a bottle of liquid medicine used for pain relief dated 3rd July 2009. We saw a label attached to the bottle which stated, 'do not use after 15th September 2009'. We were informed by a member of staff that it would be returned. This means that medication, which had expired two months ago, was still available for an identified person and increases the risk of harm to the person.

Controlled drug medication, which requires special storage was not stored according to legal requirements. We saw that the medication cabinet available for storing these medicines did not meet the requirements of the Misuse of Drugs Act 1971, the Misuse of Drugs (Safe Custody) Regulations 1973. We also saw some medication stored in this cupboard that did not need to be stored in there, which increases the risk of

Evidence:

unnecessary access to the controlled drugs. This means that there was inadequate arrangements in the home to meet legal requirements and ensure secure storage of peoples medication.

The storage temperatures of medicines were not being monitored each day and it was not possible to ensure that medicines were being stored at the correct temperature. For example, medication should be stored below 25 degrees centigrade, however there were no temperature records available for the Lead Care office or the small cupboard room where medication was being stored. A member of staff informed us that this would be done. We looked at the temperature records available for the refrigerator. Medication requiring refrigeration should be stored between two to eight degrees centigrade. We saw that the last recorded entry was dated 24th October 2009 at four degrees centigrade. We were informed that the member of staff who usually records the temperatures had been on holiday. No action had been taken to ensure the temperature records were documented. This means that it was not possible to ensure that peoples medication was being stored within the recommended temperature ranges. Medication not stored within the recommended temperature ranges are at an increased risk of deterioration making the medicine ineffective and possibly harmful to the people they are being given to.

Medication administration records (MAR) were not always documented with a signature for administration or an appropriate code documented with a reason why the medication was not given. For example, we looked at the MAR charts for an identified person and found gaps where there were no signatures for administration of two prescribed medicines. One of the medicines was to be given once a week on a Monday for the treatment of rheumatoid arthritis. We saw that there was no record of the medication being given on Monday 9th or Monday 16th November 2009. It was not possible from the records to determine whether medication had been given or if not a reason was not documented. We checked the amount of tablets available in the home but it was not possible to determine if medication had been removed from the container because the record of receipt did not match the amount of tablets we counted in the bottle. There was no date of opening recorded on the bottle. This means that due to poor records it was not clear if the person had been given their medicines for treating rheumatoid arthritis as prescribed and were at risk of harm.

Medication administration records (MAR) were not always checked for accuracy. For example, we looked at a MAR chart for an identified person and found that the printed instructions to give a medicine did not match with the printed instructions on the label of the medicine from the pharmacy.We asked to see a copy of the original prescription from the doctor. The printed instructions on the prescription were different from the

Evidence:

MAR chart and the label on the medication. We saw that the MAR chart recorded one signature for administration on the 4th November 2009 and all other dates were not signed. We checked the tablets available in the home and found that none of the tablets had been removed from the container. This means that the person had not received their medication in accordance with a doctors instructions. The medicine was prescribed to prevent the side effects of another medicine. The service had failed to check and find out how to give the medicine and therefore the person was at risk of harm.

Prescribed medication was not available to administer according to the directions of a doctor. For example, we saw a MAR chart for an identified person for a liquid medicine to be given twice a day for epilepsy. We saw that the MAR chart had been documented with a code 'o' from 6pm on 13th November 2009 to 8am on 16th November 2009. A total of six administrations had been recorded as 'o'. The code 'o' was defined on the MAR chart as 'Ran Out'. We were informed by one member of staff that the medication had not run out but the staff on duty could not find it. We were informed by a second member of staff that nobody had contacted a doctor to obtain further supplies of the medicine and nobody had informed a doctor that the person was without their prescribed medication for epilepsy. This means that the person was at risk of having an epileptic fit and therefore was at risk of harm.

We saw some medication records which were confusing and it was not clear how much medication had been given. For example, one person was prescribed an anticoagulant to thin the blood.This medication requires blood checks to ensure the correct dose is prescribed, which can vary depending on the result.We saw that three different strengths of the tablet were available in order that the correct prescribed dose could be given. When we looked at the MAR chart for the medication it was difficult to determine from the records how much of the medication had been given. For example,sometimes an 'x' was placed in a box if the strength of medication was not required or sometimes the box was left blank. Sometimes the amount of tablets given was recorded and sometimes the actual strength given was recorded. There was no consistency in how the medication was recorded.This increases the risk of a medication error and places the person at risk of harm.

Risk assessments were not available for people who were looking after their own medicines. For example, one person was looking after 20 different medicines including tablets, capsules, liquids, inhalers, creams and sprays. We found a form called 'Resident who self administer medication' which had been signed by the person to agree to look after their medication and was dated 15th May 2009. There was no record of an assessment made by the home to ensure the safety of the person taking

Evidence:

these medicines or how it was reviewed and checked.

Personal care plans were not kept up to date with information relating to peoples medication. We looked at three peoples care plans with regard to medication. The first care plan documented some details about medication on admission to the home, however it had not been updated to show a change in administration of one of the medicines. The second person had recently returned to the home from hospital. The care plan had not been updated with recent changes made to the medication whilst in hospital. The third care plan did not contain any information relating to the persons medication. This means that the care plans were not kept up to date with regard to peoples medication which increases the risk to their health and welfare.

We were informed by a Lead carer that staff had received medication training. We were informed that nine members of staff were trained to administer medication and three members of staff were currently doing a long distance learning course on medication. We were told that staff who administer medication had done in-house training and also had received training from the pharmacy on how to use their medication system. However, we found that staff were not aware of the medication they were giving to people. For example, we spoke to one lead care about a liquid medicine. They were not aware that the medication was prescribed for epilepsy and commented 'we are not nurses'.We spoke to a second lead care about a tablet prescribed once a week. They were not aware that it was for treating rheumatoid arthritis. We were informed that they had no access to a medication reference book, however one lead care commented that there was a book 'BNF' in the office. We saw a folder on a shelf in the lead care office provided by the pharmacy which contained all the necessary patient information leaflets for each medication. This means that medication was being given to people by staff who were not aware of what the medication was for and were not aware of the availability of medication information.

We saw staff speaking respectfully to the people who use the service and they maintained their privacy whilst assisting with personal care.

Daily life and social activities

These are the outcomes that people staying in care homes should experience. They reflect the things that people have said are important to them:

Each person is treated as an individual and the care home is responsive to his or her race, culture, religion, age, disability, gender and sexual orientation. They are part of their local community. The care home supports people to follow personal interests and activities. People are able to keep in touch with family, friends and representatives. They are as independent as they can be, lead their chosen lifestyle and have the opportunity to make the most of their abilities. People have nutritious and attractive meals and snacks, at a time and place to suit them.
There are no additional outcomes.

This is what people staying in this care home experience:

Judgement:

People using this service experience **adequate** quality outcomes in this area. We have made this judgement using a range of evidence, including a visit to this service.

People who use the service cannot be confident the home will be able to support them to follow their personal interests and activities. People are able to keep in touch with family, friends and representatives and the home supports them to continue these relationships. People are offered a variety of healthy meals and snacks at a time and place to suit them. Clear and accurate assessments, care plans and review of people's nutritional needs are not being maintained to ensure staff have up to date knowledge of people's care needs and to ensure they are not placed at risk of malnutrition.

Evidence:

The care plan for a person with dementia who uses the service said the person 'needs to be kept busy to stop wandering', but there was no information telling staff how this would be achieved. We looked at the 'activity' care plan and there were only three entries over a period of 13 days showing how staff had engaged with this person. Two of the three entries were when the family took their relative out for part of the day. We saw the person engaged in activities in the lounge on the day of the inspection along with other people. The activities were organised by the home's activity coordinator. She told us she records activities people have attended in 'care plan seven' and in her diary. We looked at the diary over the same 13 day period and saw the person whose care we were case tracking had attended six activity sessions,

Evidence:

although this had not been recorded in their individual care records. The staff rota shows the activity coordinator works Monday to Thursday each week. Staff told us they provide the activities on a Friday and over the weekends, although there are no extra staff on duty to ensure there is someone available to coordinate social care activities. We asked staff what activities had been provided the weekend prior to the inspection. They told us on the Saturday they had a 'film about 6pm'. They said, 'if there are enough staff we will try and do more activities'. 'Sunday there were no activities'. They told us this is normal for weekends. We asked if people were taken out into the community on trips and they said 'not very often'.

We were given a copy of two activity programmes; one was a two week programme for Monday to Thursday each week and the other a seven day, four week programme. The home also have three pets and a shop which is run by a resident. The seven day week activity programme shows weekend activities as 'pamper time, quiz/film, one to one, hand and feet care'.

The AQAA told us under the section 'what they could do better'; they could 'provide more external trips out on the mini-bus'. We asked people who use the service in a written survey if the home arranges activities they can take part in. We received 10 surveys and seven said 'always', two 'usually' and one 'sometimes'. Surveys completed by staff told us, 'residents need more attention from the activities lady, maybe more activities, people coming in, choir etc' and 'trips out with residents'. Surveys from relatives said, the home 'provide activities (many varied) for residents and their families'. Another survey said they could do better if the service had 'a realisation that all the residents have had interesting lives and would love to talk about it. 'X (person's name) needs (and wants) to join in more activities than X does, but having meals in their room (which X is definite in continuing) X rarely knows what activity is to happen on any day - or X is told at the start of the week then finds it's cancelled or altered/is advised to immediately come - an old person needs time to prepare their mind to anything. How about a note on the lunch tray to warn X of that afternoons activity'.

The home has a large lounge and two smaller rooms where people can spend time with their visitors in private. We saw people visiting the home being made welcome by the staff.

We looked at the provision of food in the home. The AQAA told us they have 'flexible mealtimes, a staggered breakfast and two sittings at lunch time. Choices of where residents would like to consume their meals are offered. Residents are invited to entertain family and friends at mealtime with the introduction of the 'Occasions

Evidence:

Lounge'. We were given a copy of the menus for a four week period. This shows they are offered a continental and cooked breakfast each day, a choice of two main courses, (there is not a vegetarian choice available each day), and a choice of the dessert of the day, fresh fruit or yoghurt. Supper is a choice of sandwiches or a main meal each day except on a Sunday when only sandwiches are provided. Dessert is a choice of pudding or cake. We observed lunch in the dining room. There were two sittings; 12 midday and 13:00hrs. The tables seat up to four people, they were nicely laid with clean cloths and flowers on each table. Condiments and drinks were provided on each table. The days menu is displayed in the entrance hall and in the dining room. The menu of the day was chicken kiev or vegetable burger with mashed or saute potatoes, leeks and green beans. Dessert was fruit sponge and custard. The meals are portioned and plated by the catering staff prior to service.

Surveys from people who use the service told us, 'food not good'. 'Sometimes vegetables are not fully cooked.' We asked people in surveys if they liked the food. We received 10 completed surveys; three people said 'always', four 'usually' and three 'sometimes'. A relative's survey said, 'food is of an unsatisfactory quality and the same menus rotate week after week. Residents are made to wait for even a cup of tea for over 30 mins'. Staff surveys told us, 'meals are nice' and their is a 'good choice of food on offer'.

We looked at the nutritional care for the two people whose care we tracked. The outcome of one person's nutritional risk assessment said there was no risk. There was no weight recorded for this person upon admission and the weight record chart was blank. The second person's assessed information said they were diabetic and had a poor appetite. No weight was recorded on the admission information. The care plan did not contain any information about the management of this person's diabetes. The person's weight chart said their weight is to be 'recorded monthly' but there was no weight upon admission and the only weight recorded since March 2009 was an entry in June 2009. We saw recent food and fluid charts showing staff were recording what this person ate and drank. We saw this person had been reassessed recently due to being in hospital. The assessment said the person is 'unable to feed himself'. This information was not in the care plan. A senior carer told us this person needs assistance with feeding. We saw this person sitting at the dining table at lunchtime and they were eating lunch unaided.

Complaints and protection

These are the outcomes that people staying in care homes should experience. They reflect the things that people have said are important to them:

If people have concerns with their care, they or people close to them know how to complain. Any concern is looked into and action taken to put things right. The care home safeguards people from abuse and neglect and takes action to follow up any allegations.
People's legal rights are protected, including being able to vote in elections.

This is what people staying in this care home experience:

Judgement:

People using this service experience **poor** quality outcomes in this area. We have made this judgement using a range of evidence, including a visit to this service.

If people have concern with their care, they or people close to them know how to complain. Overall these concerns are looked into and action taken to put things right. People who use the service cannot be confident their healthcare needs will be met to ensure they are protected from neglect of care.

Evidence:

The home has a complaints procedure which in in their Statement of Purpose and Service User guide. These documents are available in the home. The AQAA told us 'complaints raised are acknowledged within 24hrs and are investigated immediately not exceeding 28 days'. The 'complaints procedure is reinforced at resident reviews, meetings, one to one's with key workers and information in situ around the home'. Surveys completed by people who use the service, staff and relatives told us they knew how to complain. Staff told us in a survey, 'all staff are kind and caring towards residents'. 'They are encouraged to have their say and air their views and concerns'. All staff spoken with were aware of the home's complaint procedure.

A relative who completed a survey told us about a recent complaint they had made to the home. We asked to see this information when we inspected. The manager was not aware of this complaint and could not find any records of the complaint. We sent the manager the information about the complaint after seeking consent from the person who sent us the survey. We asked the manager to respond directly to this person with the outcome of her investigation.

Evidence:

We were not asked for our identification when we arrived at the home. We had not been to the home before. This does not protect the people who live and work at the home. We spoke to staff who were clear of the action they would take to safeguard the people who use the service.

The numerical information in the AQAA told us the home have received 13 complaints in the last 12 mths and they were all upheld. This indicates the service is recognising and recording complaints to enable them to improve the service. The home have made one safeguarding referral in the last 12 months. We were told about this incident. The outcome of the referral to Worcestershire County Council who are the lead agency responsible for co-ordinating safeguarding investigations is not concluded.

We have not received any complaints about the service in the last 12 months. We received the outcome of a second stage external investigation into a complaint made about the care of a person who used the service for respite. The complaint related to poor care and inadequate care records. All parts of the complaint were upheld.

The AQAA told us 'regulation 37 completed as applicable'. The home is required through regulation 37 to inform us about certain incidents which take place in the home. Staff told us about a recent incident and investigation which had taken place in the home due to an allegation of poor practice. We asked the manager about this incident. The manager confirmed they had not reported the incident to us and had not made a safeguarding referral. The reports have been carried out by the manager following the inspection.

Staff told us their concerns about people who use the service who have dementia going out into the community unnoticed as there is no alert system on the main entrance. Staff told us about a recent incident where a person left the home unnoticed and was missing until staff found then in the community 15 minutes later. We were not told about this incident by the manager.

The AQAA told us 'managers have received training and guidance of the Mental Capacity Act(MCA) including Deprivation of Liberty safeguards'(DOLs). Staff spoken with were unaware of the MCA and DOLs. This needs to be addressed as the home offers care for people with dementia. The manager confirmed there have been no applications made by the home in respect of DOLs.

Staff surveys told us they had undertaken Criminal Record Bureau(CRB) checks before they started work in the home. We looked at two staff files and they contained CRB

Evidence:

checks, which had been received before the person started working in the home.

We found serious concerns at this inspection about the home's management of medication. See health and personal care section. Following the inspection we referred four people who use the service to Worcestershire County Council due to neglect of care through poor management of medication.

Please also refer to the management and administration section of this report.

Environment

These are the outcomes that people staying in care homes should experience. They reflect the things that people have said are important to them:

People stay in a safe and well-maintained home that is homely, clean, pleasant and hygienic.
People stay in a home that has enough space and facilities for them to lead the life they choose and to meet their needs. The home makes sure they have the right specialist equipment that encourages and promotes their independence. Their room feels like their own, it is comfortable and they feel safe when they use it.

This is what people staying in this care home experience:

Judgement:

People using this service experience **good** quality outcomes in this area. We have made this judgement using a range of evidence, including a visit to this service.

The home is clean and well maintained providing a safe environment for the people who use the service. Procedures for the laundering of communal items need to be reviewed to ensure they are washed at sufficiently high temperatures to ensure people are not placed at risk of harm due to cross infection.

Evidence:

The home has been extended and parts of it have been refurbished since the last inspection. The home now offers care for 50 people in 46 single and two double bedrooms. The AQAA tells us 'as part of the refurbishment we have had a loop system installed. Call bell systems are available in every room this extends to individual call pendants being available to all residents'. All parts of the home are accessible for people who use a wheelchair.

We looked at the parts of the home used by the people we case tracked. They had single bedrooms, which were nicely decorated and peronalised by the people using the service. Window restrictors were in place in both rooms as they were on the first floor. These are required by health and safety legislation to ensure the safety of the people who use the service. The rooms were clean and tidy, although one room had a strong odour of stale urine. This indicates the home are not managing this person's urinary continence very well. We saw flannels and towels in the en-suite toilet. The manager told us these are provided by the home for communal use. We looked at how these

Evidence:

are laundered. Staff told us they wash them at 60 degrees Celsius. This is not hot enough to prevent cross infection.

Bath and shower rooms were clean and tidy and well equipped. All door locks seen on bedroom doors could be locked from the inside without a key to ensure peoples privacy, but they could be opened by depressing the door handle, but only from the inside.

We saw stair gates at the top of two staircases, which were secured by a latch. One was adjacent to a room where the person had dementia and was known to wander downstairs in the night. Please refer to the health and personal care section of this report.

We saw four communal rooms, a dining room, sun lounge, small lounge and an 'occasions' rooms where people could entertain family and friends at mealtimes in private. All these rooms were clean and nicely decorated and furnished.

In the cental courtyard of the building there is a garden, which is very well maintained with plenty of seating for people to use when the weather permits. A pet rabbit lives in this garden with its own hutch and run.

We received some very positive comments in surveys from people who use the service and their relatives. They told us, 'the home is kept clean'. 'It is a nice clean environment, nicely decorated and always looking to improve the residents stay, bringing normality into their lives'. Staff told us in surveys the 'home is always clean and tidy'. 'Providing nice clean and bright living spaces'. 'We have a nice courtyard garden for residents to enjoy and a beautiful lounge area for relaxing'.

We received a letter in June 2009 following completion of the extension from the Fire Officer telling us the fire safety audit was satisfactory. They recommended the home reviewed their fire risk assessment. We looked at the home's fire risk assessment and it had been reviewed in July 2009.

Staffing

These are the outcomes that people staying in care homes should experience. They reflect the things that people have said are important to them:

People have safe and appropriate support as there are enough competent staff on duty at all times. They have confidence in the staff at the home because checks have been done to make sure that they are suitable to care for them. Their needs are met and they are cared for by staff who get the relevant training and support from their managers.
There are no additional outcomes.

This is what people staying in this care home experience:

Judgement:

People using this service experience **poor** quality outcomes in this area. We have made this judgement using a range of evidence, including a visit to this service.

People who live at Ravenhurst cannot be confident they will have safe and appropriate support at all times as there are not enough trained and competent staff on duty at all times.

Evidence:

There were two lead care staff and five care staff on duty when we arrived at the home. The activity co-ordinator was due to work 10-4pm. A team of ancillary and catering staff are also employed. Domestic staff told us they had three cleaning staff on duty but they were short staffed at the moment. Housekeeping staff confirmed this and told us they were interviewing staff this week. Lead care staff told us staffing levels 'should be' two lead carers and four to five carers in the mornings and two lead carers and four care staff in the afternoon. There are three waking night staff. Staff told us there is sometimes only one lead carer on the afternoon shift. The activity coordinator works Monday to Thursday and lead care staff told us any acivities at the weekends are done by the care staff, but there are no extra staff on duty.

We looked at the staff rotas. They showed there are three staff on duty at night. The lead and care staff rota for days shows the staffing numbers have at times fallen below the 'normal' staffing levels and there also appears to be a current shortfall of lead care staff available. The AQAA sent to us on the 16th October 2009 tells us six staff have left employment in the home in the last 12 months. In the three months

Evidence:

prior to submitting the AQAA, 59 shifts have been covered by temporary staff or staff from an agency. The staff rotas show they are currently using relief staff at the home.

Surveys asked people who use the service if there are enough staff available when needed. We received 10 surveys and four said 'always', three 'usually' and three 'sometimes'. The response in staff surveys(six) when we asked are there enough staff told us, one said 'always', three 'usually', one 'sometimes' and one 'never'. Comments from staff said 'due to some staff sickness sometimes covering a shift maybe difficult, leading to the shift being short staffed so maybe employing a few more 'relief care staff' to come in when needed would be appropriate. This way we can concentrate more on 'person centred care'. 'Having more domestic staff on would be more appropriate as 50 bedrooms and lots of toilets need to get cleaned everyday - two domestics can't do all that in one day'. A survey from a relative told us their relative had not had a bath for three to five weeks. A survey also indicated this person should be taken for a walk daily but this is not happening due to a lack of staff. One comment said, 'there does not appear to be enough care staff'.

Staff told us, 'there are enough staff downstairs (two carers)', 'if there are enough staff we will try and do more activities at weekends'. There are 'not enough lead care staff due to two leaving last month'.

We looked at the recruitment files for two staff. All the information to show the home had undertaken a thorough process of recruitment was available with one exception. One file only had one reference. A second reference had been requested by the home but the non receipt of the reference had not been followed up.

The AQAA told us 'all staff commences company induction followed by common induction standards'. We spoke to two staff and they comfirmed they had received induction training. One care assistant told us they worked alongside another carer for two weeks. They told us they had not received any manual handling training yet so they are not allowed to do any moving and handling of people who use the service. We looked at the induction paperwork for these two staff. One set was very poorly completed. Day one and two of a three week induction programme had been signed off as completed but the rest of the document was blank. We saw questionnaires that staff complete after they have seen videos for subjects such as moving and handling, health and safety, fire, and abuse. These were either not fully completed or were blank. We spoke to a Senior Lead Carer who told us each staff member has a mentor who signs off their practical competencies for the Common Induction Standards. She told me this person was currently undertaking this induction.

Evidence:

A comment in a survey from a relative told us staff need 'training to include an understanding of how to communicate with hard of hearing'. Staff told us they had received their mandatory core training, although one person had not received any safeguarding training update and one person had not received any fire training but it was taking place on the 19th November. The manager showed us the annual training plan. For November training was planned for food hygiene, dementia, moving and handling (train the trainer) and external fire training. In December there was moving and handling training. The outcomes for people who use the service in the health and personal care and daily life and social activities are indicators that staff need further training. Please refer to the information in these sections of the report.

People who use the service and their relatives told us in surveys 'the staff are excellent', 'staff are always helpful and friendly'. 'They are very attentive to the residents and nothing is too much trouble for them'. 'The staff are friendly'. 'The atmosphere at Ravenhurst is friendly and homely and gives off positive vibes'.

Management and administration

These are the outcomes that people staying in care homes should experience. They reflect the things that people have said are important to them:

People have confidence in the care home because it is led and managed appropriately. People control their own money and choose how they spend it. If they or someone close to them cannot manage their money, it is managed by the care home in their best interests. The environment is safe for people and staff because appropriate health and safety practices are carried out.

People get the right support from the care home because the manager runs it appropriately with an open approach that makes them feel valued and respected. The people staying at the home are safeguarded because it follows clear financial and accounting procedures, keeps records appropriately and ensures their staff understand the way things should be done. They get the right care because the staff are supervised and supported by their managers.

This is what people staying in this care home experience:

Judgement:

People using this service experience **adequate** quality outcomes in this area. We have made this judgement using a range of evidence, including a visit to this service.

The management of the home needs improvement to ensure it is run safely and in the best interests of the people who use the service.

Evidence:

There have been changes to the management of the home since the last inspection in December 2006. The home had a long period without the presence of a registered manager. The current manager was appointed and came to the home in October 2008. There was a delay in submitting her application for registration to the commission and she was registered in May 2009. The home has increased in size this year from 41 to 50 places. The certificate of registration was on display in the home, but only one page. The manager was advised both pages of the certificate need to be displayed. The AQAA completed by the manager was comprehensive and sent to us promptly. This inspection has highlighted the information in the AQAA in parts does not accurately reflect the current practice and standards provided by the home. Evidence of this is given throughout this report. The AQAA tells us the 'manager has the required occupational competence and is working towards her NVQ Health and

Evidence:

Social Care Level four'. The manager has received training about the Mental Capacity Act and Deprivation of Liberty safeguards, but care staff have not received this training yet and it is not included in the training plan we were shown.

The AQAA tells us the home monitor the standards of the service through 'quality assurance questionnaires completed annually by residents and on discharge for short stay residents. We have undertaken external quality assurance audits which provided valuable customer satisfaction or dissatisfaction information. Information obtained was made available and actioned accordingly. We have monthly Regulation 26 visits, which supports quality assurance'. We asked to see the outcome and any action plan from surveys completed by people who use the service and people who have used the service for respite care. The manager told us the responsibility for this has been designated to a senior manager but it has not been done. She told us she is currently addressing this issue.

We looked at the monthly visit reports required by regulation carried out by a representative of the organisation who owns the home. The visits are not in line with the requirements in the regulation. They are not unannounced and there is no information to show they are speaking with staff and people who use the service during these visits to make any judgement about the standard of the care and environment.

The AQAA tells us their policies and procedures were last reviewed in 2007. These need to be reviewed to ensure they reflect current legislation and good practice.

The AQAA tells us 'residents are encouraged to manage their own financial affairs unless otherwise assessed as lacking capacity. All records referring to any residents' financial matters are kept secure and well maintained'. We looked at the management of people's monies for the people whose care we tracked. We saw the money is held in one account which is interest bearing and interest applied to peoples monies according to their credit balance. The accounts are reconciled each month. We were unable to locate the reconciled accounts for October 2009. The manager told us she checks this each month but there is no written evidence of these checks. We saw receipts for items purchased for people and a receipt for money received. There is only one signature on the receipt for money received, we advised they ask the person depositing the money to sign the receipt as well to provide a more robust system.

The home are required through regulation to notify us of any significant events which take place in the home. There were two significant events that had taken place recently in the home which we had not been told about. One incident should have

Evidence:

been referred to safeguarding and this had not been done.

The numerical information in the AQAA tells us all equipment has been serviced this year. We looked at the fire records and we saw weekly and monthly fire system checks were recorded. The fire risk assessment had been reviewed in July 2009. We asked to see the records of maintenance checks of the window restrictors. The manager told us they are not checked. We recommended to the manager these checks are carried out and she said she would implement them.

Are there any outstanding requirements from the last inspection?				
	Yes	☐	No	☑

Outstanding statutory requirements

These are requirements that were set at the previous inspection, but have still not been met. They say what the registered person had to do to meet the Care Standards Act 2000, Care Homes Regulations 2001 and the National Minimum Standards.

No.	Standard	Regulation	Requirement	Timescale for action

Requirements and recommendations from this inspection:

Immediate requirements:

These are immediate requirements that were set on the day we visited this care home. The registered person had to meet these within 48 hours.

No.	Standard	Regulation	Requirement	Timescale for action

Statutory requirements

These requirements set out what the registered person must do to meet the Care Standards Act 2000, Care Homes Regulations 2001 and the National Minimum Standards. The registered person(s) must do this within the timescales we have set.

No.	Standard	Regulation	Requirement	Timescale for action
1	3	14	14(1) A pre-admission assessment must be carried out prior to admission and sufficiently detailed. To enable staff to formulate a care plan necessary to ensure peoples needs can be met.	31/12/2009
2	7	15	15(1)(2) Care plans must be in place and sufficiently detailed and care needs reviewed as peoples needs change. To ensure staff understand what is required and people can be sure their needs will be met.	31/12/2009
3	8	12	12(1) The health and social care needs of the people who use the service must be promoted and provided. To ensure they are not placed at risk of harm through neglect of care.	31/12/2009

Statutory requirements

These requirements set out what the registered person must do to meet the Care Standards Act 2000, Care Homes Regulations 2001 and the National Minimum Standards. The registered person(s) must do this within the timescales we have set.

No.	Standard	Regulation	Requirement	Timescale for action
4	9	18	18(1)(a) To ensure that staff are suitably qualified, experienced and competent to safely administer medication before they administer medication to people living in the home. This is to ensure that staff are competent to administer medication to people.	31/12/2009
5	9	12	12(1) To ensure that there is an effective system in place to request, obtain and retain adequate supplies of prescribed medicines for people living in the home so that they can be given to them as and when prescribed. This is in order to ensure that people have medication available to be given to them as prescribed by a medical practitioner.	31/12/2009
6	9	13	13(2) To make arrangements to ensure that medication is stored securely at the correct temperature recommended by the manufacturer. This is to ensure that medication does not deteriorate which can make the medication ineffective	31/12/2009

Statutory requirements

These requirements set out what the registered person must do to meet the Care Standards Act 2000, Care Homes Regulations 2001 and the National Minimum Standards. The registered person(s) must do this within the timescales we have set.

No.	Standard	Regulation	Requirement	Timescale for action
			and possible harmful to people living in the home.	
7	9	13	13(2) To ensure that procedures are in place to support people to keep and take their own medicines (self-administration) within a risk management framework. This is to ensure that people looking after their own medicines are protected and are safe from harm.	31/12/2009
8	9	13	13(2) To make arrangements to ensure that controlled drugs are stored securely in accordance with the requirements of the Misuse of drugs Act 1971, the Misuse of Drugs (Safe Custody) Regulations 1973 and in accordance with the guidelines from the Royal Pharmaceutical Society of Great Britain. This is in order to ensure that controlled drugs are stored safely to prevent misuse.	26/02/2010
9	9	13	13(2) To make arrangements to ensure that records are kept of all medicines received, administered and leaving the home or disposed of.	31/12/2009

Statutory requirements

These requirements set out what the registered person must do to meet the Care Standards Act 2000, Care Homes Regulations 2001 and the National Minimum Standards. The registered person(s) must do this within the timescales we have set.

No.	Standard	Regulation	Requirement	Timescale for action
			This is to ensure that the care service maintains accurate records of medicines received and disposed of	
10	9	13	13(2) To make arrangements to ensure that medication administration records are accurately maintained. The reasons for non-administration of medication are recorded by the timely entry of an appropriate code or entry on the medication administration record; that the meaning of any such codes are clearly explained on each record; and that the person administering the medication completes the medication administration record in respect of each individual person at the time of administration. This is to ensure that the care service maintains accurate records of medicines administered to people including reasons for non administration of prescribed medicines.	31/12/2009
11	9	13	13(2) To make arrangements to ensure that care plans include detailed	31/12/2009

Statutory requirements

These requirements set out what the registered person must do to meet the Care Standards Act 2000, Care Homes Regulations 2001 and the National Minimum Standards. The registered person(s) must do this within the timescales we have set.

No.	Standard	Regulation	Requirement	Timescale for action
			information and instructions for staff in respect of administration and management of medicines, including the reasons to give medicines 'when required' and what constitutes 'needed' for the named person. This is to ensure that there are clear directions for care staff to give medicines prescribed 'when required'.	
12	9	13	13(2) To make arrangements to ensure that all medication is administered as directed by the prescriber to the person it was prescribed, labelled and supplied for. This is to ensure that people get their medicines correctly and that procedures for medicine administration are safe.	31/12/2009
13	12	12	12(1) The health and social care needs of the people who use the service must be promoted and provided. To ensure they are not placed at risk of harm through neglect of care.	31/12/2009

Statutory requirements

These requirements set out what the registered person must do to meet the Care Standards Act 2000, Care Homes Regulations 2001 and the National Minimum Standards. The registered person(s) must do this within the timescales we have set.

No.	Standard	Regulation	Requirement	Timescale for action
14	15	15	15(1)(2) Care plans must be in place and sufficiently detailed and care needs reviewed as peoples needs change. To ensure staff understand what is required and people can be sure their nutritional needs will be met.	31/12/2009
15	18	13	13(4)(c) & (6) Maintain the health and safety of people who use the service. To prevent people being placed at risk of harm or abuse.	31/12/2009
16	26	13	13(3) Foul laundry must be washed at temperatures above 65 degrees Celsius. To ensure it is thoroughly clean and controls the risk of cross infection.	13/12/2009
17	27	12	12(1) You must ensure that the numbers and skill mix of staff are appropriate to the assessed needs of people living at the home, taking into account the size, layout and purpose of the home, at all times. This is so that people can be confident that their needs will be met in a timely manner.	31/12/2009

Statutory requirements

These requirements set out what the registered person must do to meet the Care Standards Act 2000, Care Homes Regulations 2001 and the National Minimum Standards. The registered person(s) must do this within the timescales we have set.

No.	Standard	Regulation	Requirement	Timescale for action
18	30	12	12(1) You must ensure that staff have the correct skills and competences to enable them to carry out their role effectively. So that people are not placed at risk of harm through neglect of care.	31/12/2009
19	33	26	The provider must carry out monthly unannounced visits to the service in accordance with this regulation, prepare a written report and supply a copy to the registered manager. To ensure they monitor the quality of the service being provided to the people who live in the home.	13/12/2009

Recommendations

These recommendations are taken from the best practice described in the National Minimum Standards and the registered person(s) should consider them as a way of improving their service.

No	Refer to Standard	Good Practice Recommendations
1	18	Staff should ask visiting professionals for their identification before they are invited into the home to ensure people who use and work at the service are protected from harm.

Helpline:

Telephone: 03000 616161
Email: enquiries@cqc.org.uk
Web: www.cqc.org.uk

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