

Mr Wesley John Stala

Haven Lodge

Inspection report

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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

This inspection took place on 5 May 2016 and was unannounced. Haven Lodge is registered to provide accommodation for 11 older people who require care and support. There were 10 people living at the service on the day of our inspection.

The service is operated by an individual and so does not require a registered manager. The registered provider is the 'registered person.' Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At the last inspection on 9 September 2015, we found a breach of the legal requirement related to safe care and treatment, specifically the way environmental risks were managed. We also found breaches in the legal requirements relating to notifications a provider must make to CQC. We asked the provider to make improvements in these areas. We received an action plan from the provider which showed that all actions had been completed by 29 October 2015. In this inspection we found that the provider now met the legal requirements in these areas.

This report only covers our findings in relation to these requirements. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Haven Lodge on our website at www.cqc.org.uk.

In this inspection we found that some improvements had been made to the way environmental risks were managed. We found that improvements had been made to fire safety checks and also the testing of portable electrical appliances. Further improvements were required to protect people from the risk of scalding from hot water. We also found that the provider did not always have robust infection control measures in place.

Quality assurance audits were not undertaken by the provider which meant areas for improvement within the service were not identified by the provider. Sensitive personal information was not always stored securely.

We found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was in relation to good governance. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not consistently safe.

Risks in relation to the environment were not always managed appropriately.

Risks relating to the control and prevention of infection were not always adequately assessed or managed.

Requires Improvement ●

Is the service well-led?

The service was not always well led.

Quality assurance systems were not adequate to ensure that environmental risks and infection control were managed.

Confidential information was not always stored securely.

Requires Improvement ●

Haven Lodge

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014. This inspection was done to check that improvements to meet legal requirements planned by the provider after our 9 September 2015 inspection had been made.

We inspected Haven Lodge on 5 May 2016. This was an unannounced focused inspection. The inspection team consisted of two inspectors.

The team inspected the service against two of the five questions we ask about services: is the service safe; is the service well led. This is because the service was not meeting legal requirements in these areas in our previous inspection.

Prior to our inspection we reviewed information we held about the service. This included previous inspection reports and statutory notifications. A notification is information about important events which the provider is required to send us by law.

During the visit we spoke with the manager and the maintenance person. We observed the environment including communal areas and three bedrooms. We looked at a range of records relating to the running of the service.

Is the service safe?

Our findings

During our previous inspection of this service in September 2015 we found that improvements were needed to ensure people were protected from environmental risks. During this inspection we found that some improvements had been made but there were still further improvements needed.

During our last inspection we found that people were at risk of scalding themselves due to hot water temperatures in some bathrooms being above the recommended safe level. We asked the provider to take action to improve this. During this visit we saw that the provider had made some improvements but further improvements were needed. The manager confirmed that baths had thermostatic valves fitted. Thermostatic valves are designed to keep hot water at a safe temperature and prevent people from being scalded. However, we found that hot water temperatures were not being regularly tested to ensure that the valves were effective. In addition to this, thermostatic valves had not been fitted to the sinks and on the day of our inspection we found that water temperatures in some sinks were above the recommended level of 44°C. This meant that people were still at risk of scalding. Following our inspection the manager informed us that they had taken action to fit thermostatic valves to all sinks.

People were not adequately protected from risks to their health. We checked the records relating to measures taken to reduce the risk of legionella developing in the water supply. Legionella is a bacteria that can develop in stagnant water and can lead to a fatal form of pneumonia. There was no legionella risk assessment in place and checks on the water system were limited. Water storage systems were not being treated regularly to control the growth of legionella and there had been no recent water testing to identify levels of legionella bacteria. The provider did not have a system in place flush infrequently used taps, this is one way of reducing the risk of legionella. We saw a tap in an unused room which displayed signs of stagnant water developing. A member of staff confirmed that this tap was not regularly flushed. This meant that steps had not been taken to reduce the risk of legionella developing in the water supply and this was a potential risk to people's health.

During our last inspection we found that the provider had not completed the required checks on emergency lighting and fire doors. We told the provider they must make improvements in this area and during this inspection we found that the required improvements had been made. Records showed that a fire safety risk assessment had been completed by the fire service and we saw that the provider had acted upon recommendations in the fire risk assessment report. We also saw evidence that the provider was now completing regular checks on fire doors and emergency lighting as required.

In our last inspection we found that portable electrical appliances were not tested at the required frequency and that testing was not fully complete. During this inspection we saw records that all appliances had been tested at the required frequency.

Is the service well-led?

Our findings

During our previous inspection we found that the registered provider did not have effective systems in place to assess, monitor and mitigate risks relating to the health and safety of people using the service. During this inspection we found that the provider had not taken any action to implement an effective system of monitoring the quality of the service. We found continued failings in auditing and quality checking. A lack of effective systems in place to monitor and identify where improvements were needed resulted in issues relating to water temperatures and infection control not being identified or addressed.

Infection control audits did not provide a robust assessment of measures in place to prevent and control the risk of infection. We saw that one person's room had linoleum laid over the carpet to protect the carpet from spillages of body fluid. However the linoleum did not reach the walls leaving the carpet exposed, this was not an effective infection control measure and this had not been picked up in the infection control audit conducted by the manager.

The provider had not ensured that a competent person was in place to manage the risks associated with Legionella. This meant that the required checks and controls had not been put in place to reduce the risks. The lack of quality assurance systems meant that this had not been identified and acted upon.

Cleaning schedules showed that rooms were cleaned on a weekly basis. One room had been unoccupied since March, the cleaning rota showed that this room had been cleaned in April. However we saw this room was dirty and there was a strong odour in the room, the taps were unclean, there were used clothes in the laundry basket and the room was dusty. The cleaning schedule also showed another bedroom which was not cleaned for a period of 10 weeks as staff were not able to access the person's room at the time of cleaning. The cleaning audit conducted by the manager had not picked up the above issues.

In our last inspection we found that sensitive confidential information about people who used the service and staff was not stored securely. We asked the provider to make improvements but during this inspection we found that confidential information relating to people's care and support was still not being stored securely. We saw medication administration records (MAR) were kept in a communal area. Information relating to people's health and medicines could be easily accessed by residents and visitors to the service. We were able to look through the MAR charts freely. This meant that people's personal information was not stored securely. This also posed a risk that MAR charts could be removed or tampered with which would mean that the staff would not be able to support people to take their medicines correctly.

We also saw personal information about people's overnight support needs was displayed in a communal area which was accessible to other people who used the service and to visitors to the service. This meant that people using the service could not be assured that sensitive personal information was stored confidentially.

In addition to this we saw that staff files were still not stored securely. This meant that staff could not be assured that their personal confidential information was stored securely.

This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

In our last inspection we found that the provider had failed to notify CQC of significant events within the service. A notification is information about important events which the provider is required to send us by law. The manager told us that they were now aware of their responsibilities to notify CQC of significant events and we had received appropriate notifications since the last inspection.

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	Regulation 17 HSCA RA Regulations 2014 Good governance Effective systems were not in place to assess, monitor and improve the quality of the service. Regulation 17 (1)(2)(a)(b)(c)(d)(i)(ii)(f)

The enforcement action we took:

We served a warning notice in respect of this regulation and told the registered provider they must be compliant with the regulation by 22 July 2016.