Eleanor Nursing and Social Care Limited

York House and Aldersmore

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 18 March and was unannounced.

York House and Aldersmore is a care service for up to 18 people who have a learning disability or autistic spectrum disorder. People who use the service may also be living with mental health needs, a physical disability or dementia. On the day of our inspection there were a total of 17 people at the service, including one person who was staying for a period of respite care and one person who was accessing day services.

A registered manager was in post at the service. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements of the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The last inspection of the service took place on 6 March 2015 and the service was found to be good in all key areas. However since the previous inspection we had received information of concern from the local authority safeguarding team. Further information was received raising concerns about care practices by the local authority quality monitoring team.

There had been a number of changes at the service since the last inspection. The provider had carried out extensive improvements to the environment including building an extension and completing extensive refurbishment of communal lounges and dining areas. We found that, although improvements had been made as a result of the refurbishment, older areas of the premises had deteriorated. This applied in particular but not exclusively to bathrooms, toilets and ensuite facilities where the standard of cleaning and maintenance was not carried out in line with current legislation and guidance.

Staff and the management team did not deliver individualised and person centred care. This was evidenced by care delivery that relied on routines and was task orientated.

We found that systems in place to monitor the quality of the service were insufficiently robust to identify risks to people from areas where the environment was poorly maintained.

The service had breached regulation 9 of the HSCA 2008 (Regulated Activities) Regulations 2014 relating to person centred care, regulation 15(1)(a)(e)(2) relating to premises and equipment and regulation 17(2)(b) relating 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?

Inadequate

The service was not always safe.

Staff and the management team did not deliver individualised and person centred care. This was evidenced by care delivery that relied on routines and was task orientated.

The premises were not maintained to a standard of cleanliness that safeguarded people from risks relating to infection control.

Systems and procedures for supporting people with their medicines were followed, so people received their medicines safely and as prescribed.

Is the service well-led?

Requires Improvement

The service was not always well led.

Systems to monitor the quality of the service did not identify deficiencies in the standard of cleanliness which were not carried out in line with current legislation and guidance.

York House and Aldersmore

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 a focused inspection 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.

Focused inspections evaluate the quality and safety of particular aspects of care. They take place when we are following up after a comprehensive inspection, or when we have received concerns and have decided to look into them without doing a comprehensive inspection of all aspects of the service. They only ask the relevant key question(s), rather than all of them.

This focused inspection took place on the 18 March 2016 and was unannounced. We carried out this inspection due to concerns that had been raised through the local authority safeguarding and quality monitoring teams. We inspected under the key question of 'safe' and we looked at the impact of our findings on the key question of 'well led'.

The inspection team consisted of two inspectors.

Before the inspection, we reviewed all the information we held on the service. We spoke with members of the safeguarding and the quality improvement teams at Essex County Council.

During the inspection, we spoke with three people using the service. We also spoke with three members of care staff, the registered manager and the deputy manager. We examined four people's individual care records, daily logs and incident forms. We carried out informal observations of care and support between staff and people at the service. We also examined documentation relating to the maintenance of the premises and examined the environment including shared areas such as bathrooms as well as people's ensuite facilities.

Inadequate

Is the service safe?

Our findings

During our inspection we noted that many of the daily routines were fixed at pre-arranged times which did not reflect people's choices or offer many opportunities for individual preferences. The Social Care Institute of Excellence (SCIE) give examples of indicators of institutional abuse that include rigid regimes, lack of respect for privacy and dignity, not offering choice or lack of flexibility and choice for adults using the service. We saw from the daily logbook that there was a specific regime of tasks for people and staff. For example, night staff assisted some people who needed assistance with personal care at the same time every day. Other routines were also set, such as meal times, provision of hot drinks, when people were supported to the toilet and what time people went to bed. A member of staff told us, "We normally serve hot drinks at 10:30am but there are always cold drinks available."

We spoke with staff who confirmed that there were some set times for people to be woken in the morning and that in the evening staff would tell people it was bedtime. Set routines did not take into account people's individual needs and preferences.

Staff explained about their duties on a typical day. They told us that they started waking people at 7:30am and that was, "officially the routine." Then people went down for breakfast and the member of staff said they always asked people what they would like. "They can have a choice of cereals or porridge and toast with jam or marmalade. People who are able can spread their own jam and take their plates to the kitchen." Staff also told us, "In the afternoon after lunch they have activities. People have snacks between 17:30 and 18:00 and Horlicks for a hot drink at 18:30. People go to their bedrooms at 19:00." They also said, "One [person] likes to stay up, the others go to bed. We assist them into bed, the ones that aren't able bodied. We say goodnight and they go to bed." We looked at people's care plans and they did not document whether individuals had requested to be woken early for personal care or whether they liked to go to bed early.

The registered manager informed us that some people became upset when their routine was disrupted. This may have been due to the nature of their learning disability or because they had been used to the routine for many years. The registered manager was able to give some examples of how people became upset if their routine was not followed. Although the management team and staff explained that people liked the routines, it was not evident from people's individual care records how these conclusions had been reached and whether people had received independent support to make their views known, such as input from advocacy services.

We also noted other areas where people's individuality was not respected. For example we saw that a bathroom cupboard and shelving had a row of baskets on view containing people's toiletries. These toiletries were marked with people's names but storing them in the bathroom rather than their individual rooms did not reflect person centred care and also posed a risk of cross infection should anyone use someone else's toiletries. We also saw that a dirty sponge had been left on the window sill in the bathroom. The registered manager told us that this should not happen and staff were aware that people's toiletries should not be left in bathrooms. They confirmed that this would be rectified straight away. We noted in one person's bedroom that continence products were stored in open view. The bedroom door was kept open

and the continence products could therefore be seen by anyone walking past the open door. This did not reflect that the person's dignity was respected.

This is a breach of Regulation 9(1)(b)(c) of the HSCA 2008 (Regulated Activities) Regulations 2014, Person centred care.

Staff kept a logbook to record a list of daily activities, tasks and events that occurred. However, we found that this information was not always recorded in the daily notes for people. For example the log book documented that a person had fallen but this was not recorded in that person's notes. Notes did not accurately reflect what had happened for the person and what staff had done to support them.

A member of staff told us how they supported people if they displayed difficult behaviours or became distressed. They said they would ask, "What's the matter" and talk to the person. They gave one example of what one person liked to do to calm down and said they might also take someone round the garden or see if they wanted anything to eat. They added, "We don't send people to their rooms." Another member of staff told us if people become distressed they would use a calm, reassuring tone of voice. Depending on the care plan they might suggest that someone go to their room and gave an example of one person they would say this to. They said they had not experienced 'refusal' but if that happened they said, "I suppose I would ask the others to leave to keep them safe." They said they did have accident and incident book but if it was just that someone was distressed it would be recorded in the log book; the incident or accident book would be used for falls or violent incidents where someone got hurt. Entries in the daily log identified when people had become agitated but the record did not contain any information as to the cause of a person's distress and did not reflect whether staff understood why the person was distressed.

During our inspection we noted that the environment in people's individual bedrooms was not well maintained. In four separate bedrooms we saw a range of areas that were unclean or required repair. Flooring was not well maintained in many areas, including laminate flooring in two rooms which had been laid on top of the old carpet. The carpet was protruding in places from underneath the laminate. The edges had not been sealed or finished in any way and these unfinished edges were a potential entry point for dirt that would not be accessible and would prevent effective cleaning. One of the bedrooms had a wrinkled carpet on the floor which was a trip hazard. The surface of the floor covering in one en-suite was peeling which would prevent effective cleaning.

A member of staff told us that there were about six people who required support with washing and dressing when they got up in the morning. They explained that they used the downstairs shower room and said, "We go up and wake them and dress them." They said that people who were more independent used the upstairs bathing facilities. They confirmed that both upstairs and downstairs bathing facilities were used on a regular basis.

There were a number of areas in people's en-suite facilities that needed to be repaired, including one with a cracked toilet seat and three with broken lights. These areas did not have windows and without a working light people would have to leave their toilet doors open in order to have sufficient light to have a wash, clean their teeth or use the toilet. The ceiling in one en-suite where the light was not working was badly stained by water damage. In one person's en-suite we noted that the toilet roll holder did not have any toilet roll and the holder was fitted in a position where it was too far away from the toilet to be reached.

Toilets in two rooms were badly stained, there was an unpleasant odour and we noted a significant build-up of dirt round the base of the toilet in one room. We also observed sealant along the edge of a bath that was peeling off and the side bath panel was loose and hanging off. All areas examined had a significant amount

of lime scale which had built up around taps.

Communal bathing facilities also were poorly maintained and unclean. In the upstairs bathroom we noted a broken shower head and heavy deposits of lime scale had built up around the bath. The handrail affixed near the bath was rusty and rough, posing a risk of tearing the skin of anyone using it for support to mobilise when using the bath. Tiles were broken in places exposing sharp edges and there was also a broken toilet roll holder in the bathroom. We saw that the bath seat was dirty and the seat in particular was soiled, posing a risk of cross infection.

In the wet room area there was a significant build-up of grime around the water outlet. A shower chair used for people who needed to sit when being supported to shower was dirty. We saw from the log book that a number of people had had a shower during the morning, but there was no recorded evidence that the shower chair had been cleaned in between showers. The drains in shower areas were dirty and there was a strong smell of damp in all these areas. The downstairs wet room contained a broken bin and in the downstairs shower there was a smell of damp and the flooring was peeling back. The downstairs bathroom also had flooring coming away and there was mould visible by the edge of the bath

We noted that the downstairs toilet, which we were told was the staff toilet, was cleaner than the toilets and en-suite facilities in people's individual rooms or in the communal bathing facilities.

We saw that the laundry room door had been left open and inside a large bottle of cleaning fluid was exposed and accessible to anyone entering the room. We found that a wall cupboard contained more cleaning products, and whilst it had a lock in place to keep these substances safe, it was unlocked. A boiler cupboard containing exposed hot pipes was also open. This cupboard had a health and safety 'keep locked' sticker in place. Staff were unsure about whether it should be open or locked. They said there had been some conflicting advice. A member of staff said that they had been concerned about the cupboard being left unlocked because they recognised the potential risk to people, but had not contacted the Health and Safety executive to ascertain what to do.

We noted that a large stained glass window on the stairway contained some cracked and broken panes of glass. This had not been secured in any way to prevent the loose glass from falling out. This was a potential hazard for people using the stairs.

These poorly maintained areas, damaged surfaces and areas that were unclean were an infection control risk. The Health and Social Care Act 2008 Code of Practice on the prevention and control of infections and related guidance (updated July 2015) sets out criteria providers must comply with to keep people safe from risks relating to infections. Criterion 2 states that the registered provider needs to provide and maintain a clean and appropriate environment that facilitates the prevention and control of infections. Criterion 6 requires the registered provider to ensure that all staff and those employed to provide care are fully involved in the process of preventing and controlling infection. We found the service had not followed the Code of Practice.

This is a breach of Regulation 15(1)(a)(e)(2) Premises and equipment

Following our inspection the provider sent us confirmation that remedial action had been taken to rectify some of the issues identified, including photographs of areas that had been cleaned and confirmed that all hazardous substances had been secured in a padlocked cupboard. They also informed us that work was ongoing to refurbish people's ensuites. Other work such as replacing flooring was scheduled to be done. We will follow this up at our next inspection to confirm whether the outstanding work has been completed and

improvements have been sustained.

We saw that there were sufficient staff to support people with their care and support needs. A member of staff explained that there were only about six people who required support to get washed and dressed and there were enough staff to do this. They told us the staff team had got better than in the past and told us the team, "respond more promptly to people." We saw that staff spent time with people doing in-house activities. A member of staff told us that sometimes they will go out with someone for a walk along the seafront or for a walk to the coffee shop up the road.

The service had robust procedures in place for storage, administration, and disposal of medicines. Staff received appropriate training and underwent observations to ensure that they were competent to administer medicines. Audits were routinely undertaken and when errors were identified staff had to undergo further training and observations by the deputy manager. Staff kept daily records of fridge and room temperatures to ensure safe storage of medicines that needed to be stored within a specific temperature range to prevent them deteriorating. When medicines had a short storage life, staff had recorded dates of when they had been opened and needed to be disposed of. People who required medicines outside of regular times were identified and we saw that they received their prescribed medicines in a timely manner.

Requires Improvement

Is the service well-led?

Our findings

There were systems in place for monitoring the quality of the service. Part of these systems included environmental audits and we examined records of environmental checks that had been carried out. These included monthly room checks. One person's room had been audited four days before our inspection. The record confirmed that the room had 'passed' the ensuite quality check but we found the toilet in this en-suite was badly stained. Two other rooms that had been audited in the previous three months and had also been recorded as having 'passed' had a significant shortcomings. These included a build-up of grime, badly stained toilets, damage to the flooring and an unpleasant odour. Other rooms that were poorly maintained did not have any records to confirm whether they had been audited.

It was evident that the quality process for checking the environment was not sufficiently robust as the issues that we observed had not been picked up during the audits and actions for improvement identified.

Staff had told us that part of the keyworker's role was to "do a deep clean" of people's ensuite facilities. Staff understood that this was part of their role, however the standard of cleanliness and maintenance was below what would be expected if staff were following good practice. This had not been identified through the management team's quality monitoring processes.

This is a breach of Regulation 17(2)(b) Good governance.

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	Regulation 9 HSCA RA Regulations 2014 Person-centred care People's care and support was provided in a routine and regimented manner and did not ensure that people received person-centred care that reflected their personal preferences. This is a breach of Regulation 9(1)(b)(c) of the HSCA 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The environment was not sufficiently clean and well maintained to protect people from risks associated with infection control or poorly maintained premises. This is a breach of Regulation 15(1)(a)(e)(2).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Processes to monitor the quality of the service, including the premises, were not effectively used to identify areas of the environment that required improvement. This is a breach of Regulation 17(2)(b) of the HSCA 2008 (Regulated Activities) Regulations 2014.