

Haversham House Limited

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Inspection report

Longton Road
Trentham
Stoke-on-Trent
ST4 8JD

Tel: 01782643676

Date of inspection visit:
02 March 2021
03 March 2021

Date of publication:
07 April 2021

Ratings

Overall rating for this service

Inadequate ●

Is the service safe?

Inadequate ●

Is the service well-led?

Inadequate ●

Summary of findings

Overall summary

About the service

Haversham House Limited is a residential care home providing personal and nursing care to 32 people aged 55 and over at the time of the inspection, some of which were living with dementia. The service can support up to 49 people.

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

People did not always have care plans and risk assessments in place or reflective of their needs, to enable staff to meet these. People were not consistently supported by staff trained in all of their healthcare needs to enable them to meet these effectively. People were not supported in a clean and well maintained environment and there were not sufficient staff to maintain a clean environment. There were areas of the home that were unsafe with exposed hot water pipes and uncovered radiators.

People's medicines records were not always complete and did not consistently contain guidance where they were prescribed medicine on an 'as required' basis. People's medicines were not always disposed of in a timely way where these were no longer prescribed.

People were not always supported by staff to isolate in line with government COVID-19 guidance on admission to the service. The provider had failed to act on concerns raised by external professionals around infection prevention and control practices.

Quality assurance tools were not effective at identifying areas of concern in relation to people's care files, infection control, the environment, medicines and staffing and ensure action was taken to implement improvements in a timely way. The provider had failed to ensure lessons were learnt when things went wrong and improvements were made at the home where these were required.

People were supported to access medical professionals as they required these. People were supported by staff that understood safeguarding and had raised concerns appropriately as required.

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

Rating at last inspection

The last rating for this service was requires improvement (published 27 January 2021). The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection enough improvement had not been made and the provider was still in breach of regulations. The service is now rated inadequate. This service has been rated less than good for the last four consecutive inspections.

Why we inspected

We undertook this focused inspection to check whether the Warning Notice we previously served in relation

to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 had been met. We had also received concerns from external professionals about people's safe care and treatment, infection control practices and the governance and oversight of the home. We reviewed the information we held about the service and as our concerns were within the domains of Safe and Well led we inspected these domains only.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

Enforcement

We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to people's safe care and treatment, the cleanliness and maintenance of the home, staffing and oversight.

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

Follow up

We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

Special Measures

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate ●

The service was not safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate ●

The service was not well led.

Details are in our safe findings below.

Haversham House Limited

Detailed findings

Background to this inspection

The inspection

This was a focused inspection to check whether the provider had met the requirements of the Warning Notice in relation to Regulation 17 good governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and to follow up concerns that had been shared with us in relation to people's safe care and treatment, infection control practices and the oversight within the home.

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

Inspection team

The inspection team consisted of two inspectors.

Service and service type

Haversham House Limited is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service did not have a manager registered with the Care Quality Commission. This means the provider is legally responsible for how the service is run and for the quality and safety of the care provided. There was a consultant in place during our inspection working with the provider to make improvements at the home.

Notice of inspection

We gave a short period notice of the inspection. This was because it is a small service and we needed to be sure that the nominated individual would be in the office to support the inspection. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

What we did before the inspection

We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. The provider was not asked to

complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During the inspection

We spoke with two people who used the service and five relatives about their experience of the care provided. We spoke with 11 members of staff including the nominated individual, consultant, deputy manager, senior care workers, care workers and domestic staff. We reviewed a range of records. This included five people's care records and multiple medication records. We also looked at a variety of records relating to the management of the service, including policies and procedures.

After the inspection

We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records. We spoke with three professionals who regularly visit the service.

Is the service safe?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now deteriorated to inadequate. This meant people were not always safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

- People were not protected from avoidable harm as we saw exposed hot water pipes and an uncovered radiator. We also saw a boiler room with pipes that were hot to touch was unlocked and the locking mechanism on the door was not sufficient to stop people from opening it. There were people living with dementia at the home who experienced periods of confusion and required support to maintain their safety. Exposure to uncovered pipes and radiators placed people at risk of burns.
- People continued to not have care plans and risk assessments in place which contained accurate and up to date guidance for staff to follow. For example, one person had a diagnosis of epilepsy and had no care plan or risk assessment in place providing guidance to staff on how to meet these needs. This person's care plans were highlighted as a concern at our previous inspection and no improvements had been made.
- The provider had failed to ensure staff had sufficient training to meet people's health care needs. For example, one person at the service had epilepsy however staff were not trained in this. Whilst staff we spoke with were aware this person had epilepsy, they did not all know what action to take in the event of them experiencing a seizure. This placed the person at risk of not receiving support in line with their epilepsy care needs in a timely way as staff would have to wait for a senior staff member to support.
- One person did not have any care plans or risk assessments in place apart from a falls risk assessment. This placed the person at significant risk of not receiving care in line with their needs, as the home was using agency staff who did not know this person well.
- Staff did not have clear guidance around how to support people with their mobility needs. For example, one person's care plan advised they should use the hoist 'as required', however contained no detail for staff around how or when this support should be offered. This person had a health condition which meant their mobility needs fluctuated. Staff not having clear guidance in place on when and how to use the hoist to support this person placed them at risk of not receiving care in line with their needs.
- The consultant told us they were making improvements to people's care plans. However there was no effective system to ensure care plans contained sufficient guidance for staff to meet people's needs whilst this process was being completed. This placed people at risk of harm.

Using medicines safely

- At the last inspection we raised concerns around medicines records in relation to people who were prescribed their medicines via a patch. At this inspection we found improvements had been made to staff documentation in regard to patches. However further improvements were now required to other aspects of medicines documentation, storage and oversight.
- People did not consistently have clear guidance in place for staff where they were prescribed medicines 'as required'. For example, five people did not have this guidance in place and this placed people at risk of

not receiving their 'as required' medicines as prescribed.

- During this inspection we found medicines stored within the medicines fridge that were no longer prescribed. For example, we found three creams within the medicines fridge that had not been prescribed for people since January 2021. Staff we spoke with confirmed there was no system in place for checking the medicines stock in the fridge.
- People received their medicines by trained staff and had access to medical professionals to review their medicines where this was required.

Preventing and controlling infection

- At the last inspection we signposted the provider to resources around using PPE (personal protective equipment) and admitting people to the service safely. At this inspection we found improvements had not been made in relation to people being admitted to the service safely and in line with government guidance on COVID-19. For example, two people admitted to the service following discharge from hospital were not isolated in line with government guidance for the recommended 14 days. This placed those around them at increased risk of transmission of COVID-19.
- Staff were storing their personal clothing within the communal areas of the home. This increased the risk of exposure to COVID-19.
- The provider had failed to ensure staff were taking people's temperatures twice daily in line with government COVID-19 guidance. This placed people at risk of harm.

Systems were not in place or robust enough to ensure people's documentation reflected their needs and prescribed medicines and enabled them to receive consistently safe care. This placed people at risk of harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The home was visibly unclean and we observed, dust, dirt and debris on the floors and carpets. We also saw unknown spillages on the walls within the communal areas and corridors.
- Areas of the home required maintenance to enable effective cleaning. For example, handrails and doors required varnishing to enable these to be cleaned. We also saw people's over the chair tables were damaged and had water permeation making them unable to keep clean.
- There was no flooring in the staff room and this was visibly unclean. This is the area staff change from their personal clothes to their work clothes. Failure to ensure this room was well maintained to enable effective cleaning increased the risk of transmission of COVID-19.

Systems were not in place to ensure there were effective infection prevention and control measures within the home in line with government guidance on COVID-19. The home was unclean and required maintenance to enable effective cleaning. This placed people at risk of harm. This was a breach of regulation 15 (premises and equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider took action following the inspection site visit to replace damaged equipment and begin the cleaning of the home. We will check improvements have been made at our next inspection.

Staffing and recruitment

- There were not enough staff to ensure the home was kept clean. The home had a maximum of two domestic staff on duty per day, one who was responsible for the laundry and one who was responsible for the cleanliness of the home. One staff member told us, "I see the mess around me and know it's physically impossible to sort it." The home had 49 bedrooms with multiple communal areas and it was not possible for one staff member to maintain this, alongside ensuring enhanced cleaning in line with government COVID-19

guidance was completed. This placed people at risk of harm of increased risk of transmission of infections.

- There was also not sufficient staff to ensure the home was well maintained. At the time of the inspection there was one maintenance person working with the home with multiple areas of the home requiring maintenance. For example, there were chips to the plasterwork walls and skirting. Many of the maintenance works required were ongoing from our previous inspection. This placed people at risk of harm as some of these areas were unable to be cleaned effectively until the maintenance work was completed.

Systems were not in place to ensure there were sufficient staff to maintain the cleanliness and maintenance of the home. This placed people at risk of harm. This was a breach of regulation 18 (staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider took action following the inspection site visit to employ additional temporary staff and contractors to support the additional domestic and maintenance staff to enable improvements to take place. We will check improvements have been made at our next inspection.

- Despite this, people needs were met by staff in a timely way and we observed people did not have to wait for their care. One staff member told us, "We are never short of staff as [the management team] always get agency staff in. We have enough time to ask if people are ok."
- Staff had been recruited safely in line with the provider's policies

Learning lessons when things go wrong

- We could not be assured lessons were always learned when things went wrong as improvements that were required at previous inspections had not been implemented.
- Accident and incidents were reviewed by the registered manager to ensure they had been investigated and reviewed to enable improvements to be implemented where required.

Systems and processes to safeguard people from the risk of abuse

- People and relatives told us they felt safe and staff we spoke with had safeguarding training and were knowledgeable about the different types of abuse. One staff member told us, "I would report [concerns] to the senior, but if they didn't do anything I would go the manager and if nothing still I would report to safeguarding. I would obviously support [the person] through this process." We saw where staff had raised concerns, these had been reported to the local safeguarding team where required.

Is the service well-led?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now deteriorated to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

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

At our last inspection the provider had failed to ensure quality assurance tools had identified where improvements were required at the service and change was implemented effectively. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found there had not been sufficient improvements and the service remained in breach of regulation. This was the fourth consecutive breach of regulation 17.

- The provider had failed to ensure effective quality assurance tools were in place to identify where areas of improvement were required and where improvements were identified, to action these in a timely way. For example, as discussed within the domain of 'Safe' we found the home was unclean and areas were in need of repair. The consultant told us they completed a daily walk around of the home to identify where areas of improvement were required. However, this was not documented and no improvements had been made in response to these walk arounds. This placed people at prolonged risk of harm.
- The provider had failed to ensure improvements required by external professionals were implemented to enable people to receive consistently safe care. For example, external professionals completed an infection prevention and control visit on 12 February, in which 116 actions were identified for improvement. Despite this, no action had been taken to make the required improvements at the time of our inspection visit.
- The provider had failed to ensure effective quality assurance tools were in place to identify where improvements were required to people's medicines documentation. For example, there was no system in place to ensure medicines stored in the fridge were disposed of following them no longer being prescribed.
- The provider had failed to ensure there were effective systems in place to ensure government guidance in relation to COVID-19 was consistently followed. This was a continued concern from our previous inspection.
- Audits on people's care records had continued to fail to identify where these were not in place and did not reflect people's needs. For example, one person's care records stated they had a diagnosis of diabetes, however this was not the case. This placed people at risk of not receiving care in line with their needs as the home were using agency staff due to gaps in recruitment who did not know people as well as the regular staff members.
- The provider had failed to implement and embed improvements and to ensure compliance with the regulations for four consecutive inspections. This meant people had consistently received care that was less than good over a prolonged period.

This is a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The provider had displayed their previous rating clearly on entrance to the service and on their website.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people;

- Relatives and staff gave mixed feedback about the provider and management team and the level of communication they received from them. One relative told us, "It would have been nice to know the changes that are happening at the home. It's a very difficult time. We haven't had any communication on visiting."
- People and their relatives gave positive feedback about staff. One relative told us, "[Staff] are always friendly and very patient."
- The management team worked with us during the inspection to address areas of immediate concern we raised in relation to the cleanliness and maintenance of the home.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- Feedback questionnaires for people and their relatives had been sent out just prior to our inspection. We will check any actions identified from people and their relative's feedback has been considered at our next inspection.

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

- The provider understood their responsibilities under the duty of candour and was meeting these.