Mr Stephen John Oldale

Emyvale House

Inspection report

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Date of inspection visit: 28 May 2015
Date of publication: 19/08/2015

Ratings

Is the service safe?	Inadequate

Overall summary

We last carried out an inspection under the Care Quality Commission's old methodology on 1 August 2014 and on 1 October 2014. In May 2015 we received concerns in relation to people's safety. The concerns were lack of staff on duty to meet people's needs, concerns relating to one of the rooms and that 18 people were being accommodated when the service was only registered to provide accommodation for 16 people. As a result we undertook a focused inspection to look into those concerns.

This report only covers our findings in relation to this topic. You can read the report from our last inspection, by selecting the 'all reports' link for Emyvale House on our website at www.cqc.org.uk

We undertook this focused inspection to determine people who used the service were safe. We have not yet carried out a comprehensive inspection to provide a rating for this service under the Care Act 2014

Emyvale House is situated in the village of Wath-Upon-Dearne which is approximately six miles from the town of Rotherham. The home provides accommodation and care for up to16 older people.

Bedroom facilities are provided on the ground, first and second floor level of the building. Access to the first and second floor is by a lift. There are communal areas including a lounge, small conservatory and a separate dining area. There is a car park at the front of the building and gardens to the rear.

The home had a registered manager who has managed the service for 12 years. A registered manager is a person who has registered with the Care Quality Commission to manage the service and has the legal responsibility for meeting the requirements of the law, as does the provider.

At this inspection we found, while most people said they were very happy with the service and praised the staff very highly, some also raised a number of concerns. Our observations and the records we looked at did not always match the positive descriptions some people gave us. We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in that people did not receive safe care and treatment and there were not always enough staff on duty to meet people's needs.

Summary of findings

The provider had safeguarding policies and procedures in place to guide practice. Staff we spoke with were aware of procedures to follow including whistleblowing if it was necessary. However we found safeguarding concerns during our inspection and we submitted two safeguarding referrals to the local authority following our visit.

There were not always enough staff to meet people's needs. People who lived at the home told us the staff were very good, worked hard and tried to ensure they met their needs. However, people also said the staff were always very busy. One person told us, "At night sometimes I wait a long time for assistance, staff tell us they are busy with other people." Relatives we spoke with praised the staff and told us they were very caring and considerate, but at times were extremely busy and more staff were required.

People's needs had not always been assessed. We found no care plans were in place for people who received a respite service. Risk assessments relating to health, safety and welfare of people who used the service had not been completed. This put people at risk of inappropriate care that did not meet their needs.

We found that the provider had on an occasion had 17 people staying at Emyvale house when it was only registered for 16. The extra person was accommodated in an attic room that was not fit for use.

Summary of findings

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.

Staff we spoke with were aware of safeguarding procedures to follow. However, we found safeguarding concerns during our inspection and we submitted two safeguarding referrals to the local authority following our visit.

There was not always enough staff to provide people with individual support required to meet their needs.

People's needs had not always been assessed. Risk assessments relating to health, safety and welfare of people who used the service had not been completed.

People were being accommodated in rooms that were not safe.

Emyvale House

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 to determine people were safe. We inspected this service against one of the five questions we ask about services: is the service safe this was because we had received information of concern.

This inspection took place on 28 may 2015 and was unannounced. The inspection team consisted of two adult social care inspectors who were accompanied by a local authority contract officer.

Before our inspection we reviewed some information we held about the service. The provider had not completed a provider information return (PIR) as we had not requested one. The pre-inspection information pack document is the provider's own assessment of how they meet the five key questions and how they plan to improve their service. We spoke with the local authority, contracts officer, commissioners and safeguarding vulnerable adult's team.

At the time of our inspection there were 17 people living in the home, however one person was in hospital so 16 people were in at the service at the time of our visit.

We looked at other areas of the home including some people's bedrooms, communal bathrooms and lounge areas. We spent some time looking at documents and records that related to peoples care, including care plans, risk assessments and daily records. We looked at five people's support plans. We spoke with five people living at the home and two relatives.

During our inspection we also spoke with eleven members of staff, which included care workers, domestics, kitchen staff, the regional manager and two registered managers from other services.

Inadequate

Is the service safe?

Our findings

People who lived at the home and their relatives we spoke with told us they felt safe and did not have worries about any of the staff or other people who used the service. However people told us staff were always very busy and sometimes rushed.

One person told us, "The staff are lovely, they work very hard." Another person said, "I think the staff are great I have nothing bad to say, but they are very busy and we could do with more at times."

The provider had safeguarding policies and procedures in place to guide practice. Staff we spoke with were aware of procedures to follow including whistleblowing if it was necessary. All staff we spoke with told us they had received training and would not hesitate to report any suspected abuse immediately. However during our inspection we identified safeguarding concerns and following our visit we submitted two safeguarding referrals to the local authority.

All care staff we spoke with were concerned regarding the staffing levels. They told us there is only usually two staff on each shift and it was not enough to ensure all people's needs were met. People we spoke with told us the staff could be very busy and at times you had to wait for assistance. On the day of our visit there were two care workers on duty their hours of work were 7am – 2.30pm. There was also a domestic on duty and an additional worker came on duty at 11am – 7pm, this person told us their duties were to do some cleaning, prepare tea and help with meals and laundry.

The service was a converted older house with bedrooms on three floors. From looking at care files and talking with staff we found that four of the 16 people who were using the service required two staff for all care needs. This meant if the two staff were with one of these people, no staff were available to other people who used the service. We also identified one person was continually trying to leave the service and staff had to monitor them closely to ensure their safety. This meant people would have to wait and assistance would not be given in a timely manner and put people at risk of harm.

We discussed this with the regional manager who told us they had been told by staff that they were struggling to manage so they had allocated the additional worker from 11am to 7pm from 24 May 2015. This was to help with cleaning, meals, drinks and laundry to ensure the care staff were available to provide care at all times. We asked if a dependency tool was used to determine the staffing levels required. We were told this did not take place but the regional manager agreed to look at this and implement a dependency tool.

We were shown the staff rotas and found that on many occasions there were only two staff on duty. We also identified that over a period form 22 – 26 May the home was providing accommodation for four people who required respite care in addition to the 13 people who resided permanently at Emyvale House. This was a total of 17 people who were using the service. We were told by staff that one person spent the day at Emyvale but at night was taken to another home to sleep. This service was co-owned by the provider of Emyvale House.

This was a breach of Regulation 18 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We also ascertained that on 25 May 2015 the home accommodated 17 people. This was because one of the permanent people who used the service was discharged form hospital. This also meant during the day 18 people were cared for at Emyvale. On the 25 May 2015 there were two care workers, one cook and one additional staff member cleaning, helping with meals and the laundry. The staff we spoke with said that over this period they had struggled to meet people's needs safely. All staff we spoke with were caring, understood people's needs and were genuinely concerned for people's safety.

When the service accommodated people who received respite care these people were moved to different rooms wherever a room was vacant. People we spoke with said this was very confusing. One person said, "I have been in most rooms here, I do get confused the girls [care staff] have to take me to my room as I can't remember which one it is." One of the rooms that was used was in the attic. It had a lowered ceiling, no water supply, no toilet, no fixed call system installed and the bed was a fixed narrow bed. The room was not 'fit for purpose' or safe for people to use.

We looked at accident records for May 2015 and there had also been seven other incidents and we found all seven incidents had occurred at night. This was when only two staff were on duty in the service. None of these incidents were witnessed by staff and all of the people were found on the floor. This put people at risk of harm.

Inadequate

Is the service safe?

We looked at the care plans for people who received a respite service. We found that people's needs had not been assessed, no risks assessment were in place and from the records it was not possible to determine what the persons needs were or how to ensure they were met.

One person who was receiving respite care required assistance with moving and handling and used a stand aid, none of this was documented in their care plan. Another person regularly visited the service for respite care, yet no care plan was in place for this person. The staff we spoke with told us they completed a body map and we found daily records were recorded on a sheet entitled, 'daily support plan reference sheet'.

Another person's records we checked had a pressure ulcer assessment in place, which had identified the person had very high risk of developing pressure ulcers. However, there was no plan in place for staff to follow to ensure this person's needs were met and that the risks were managed.

This was a breach of Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing **Sufficient numbers of competent skilled staff were not deployed to meet the needs of people who used the service.** Regulation 18 (1)

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment People were not protected against the risks of receiving care or treatment that was unsafe. The delivery of care did not always meet people's needs and risks relating to people's health, safety and welfare were not identified. Regulation 12 (1) (2) (a) (b) (d) (I)

The enforcement action we took:
We have issued a Warning Notice which we have asked the provider to comply with by 24 July 2015