Tracey Hope

Hope Residential Care

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection of this service on 16 and 21 July 2015. Breaches of legal requirements were found. After the comprehensive inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to the breaches.

We undertook this focussed inspection on 08 and 11 December 2015 to check that the provider had followed their plan and to confirm that they now met legal requirements. We also looked at concerns we received prior to the focussed inspection about on call management arrangements to support staff members working alone, staffing levels and the financial viability of the service. This report covers our findings in relation to those requirements and the concerns brought to our attention. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Hope Residential Care on our website at www.cqc.org.uk.

Hope Residential Care Home is situated on Waterloo Road in the residential area of south shore Blackpool. Off street parking is available for visitors. The home is registered to provide accommodation for a maximum of twelve people. At the time of our inspection visit there were six people who lived there. Bedrooms were located on the ground and first floor. Communal space comprised of a lounge and a dining room on the ground floor.

The registered provider was an individual who also managed the home on a day to day basis. Registered providers are 'registered persons'. 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. The registered provider was not present during our inspection.

During the comprehensive inspection of this service on 16 and 21 July 2015 we found recruitment procedures were unsafe. This was because the registered provider had employed people before appropriate checks had been completed. These checks were required to ensure staff working at the home were safe to work with vulnerable people. This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

During this inspection the recruitment records of one person employed since our inspection on 16 and 21 July 2015 were not available. This meant we were unable to identify appropriate checks had been made to ensure the person was safe to work with vulnerable people.

We also found whilst reviewing a selection of employment records that one member of staff had been employed since 2013 without a Disclosure and Barring Service check (DBS).

This was a continued breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

During the comprehensive inspection of this service on 16 and 21 July 2015 we found the registered provider had not notified the Care Quality Commission (CQC) without delay of the death of a person who lived at the home, allegation of abuse and an application to deprive a person who lived at the home of their liberty. This was a breach of Regulations 16 and 18 of the Care Quality Commission (Registration) Regulations 2009.

During this inspection we found the registered provider had not fulfilled their regulatory responsibilities. This was because they had not submitted a notification to CQC about an injury suffered by a person who lived at the home. The injury had been sustained since our last inspection.

We also found the registered provider had not submitted a notification to CQC about the financial viability of the service and staffing situation which was likely to threaten to prevent, the service provider's ability to continue to carry on the service safely.

This was a continued breach of Regulation18 of the Care Quality Commission (Registration) Regulations 2009.

Through our observation and discussions with people who lived at the home and staff we noted that a number of systems to keep people safe had failed. There were numerous breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 which meant the service was not safe or well-led. You can see what action we told the provider to take at the back of the full version of the report.

We found suitable on call management arrangements were not in place to support staff working alone in the home. We were told by staff members about occasions when they had been unable to contact the registered provider when they required assistance to support people in their care. This meant people did not always receive the care and support they required when they needed it.

We found the induction training for new staff wasn't structured and organised. One staff member told us they had not received any induction training and had been left to work on their own for periods of time during their first few weeks of employment. This meant people who lived at the home had been supported by a person who wasn't suitably trained and experienced to support them.

We found one staff member responsible for the administration of medicines had received no medication training or been assessed to ensure they were competent to support people with their medicines prior to being left alone to administer medicines. This meant people who lived at the home had been potentially placed at risk from unsafe management of their medicines.

We found the environment had not been well maintained and lacked investment. We saw carpets which were frayed and a potential tripping hazard to people who lived at the home.

We found furnishings in some rooms were in a poor state of repair. The cupboard door to a vanity unit in one room was broken and hanging off its hinges.

Maintenance records including gas, fire and electrical installation certificates were not available for inspection. This meant records were not available for the regulated activity and we were unable to confirm these facilities had been serviced and were safe for use.

We found the home did not have a working tumble dryer and people's wet clothing was dried on radiators around the home. This created an unpleasant smell of dampness and was undignified for people who lived at the home.

Two staff members told us they had been instructed by the registered provider to leave the heating turned off until 4pm. We were told people were provided with additional clothing and blankets to keep them warm when the heating was turned off.

We found arrangements for meal provision were poor. Staff told us about occasions when they had purchased bread and milk with their own money because of the lack of funds available to them from the registered provider. This was as recent as the week before the inspection.

We found the falls risk assessment for one person identified as being at risk of falling had not been recently reviewed. There was no information recorded to identify how staff lone working would manage the person in the event of them falling.

We found appropriate procedures had not been followed to record safeguarding concerns, accidents and incidents and take necessary action as required. This meant people were not always safe.

We identified during the inspection the registered provider had not taken all reasonable steps to ensure the financial viability of the service. This was evident in the lack of investment in the environment and funds not being available for food provisions.

After the inspection took place the registered provider made the decision to close the service.

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.

Recruitment procedures the service had in place were not safe. Safety checks had not been completed before staff commenced working at the home.

The registered provider failed to deploy sufficient numbers of staff to support people who lived at the home. On call management arrangements were poor leaving staff without appropriate management support.

Staff did not receive appropriate training to enable them to carry out the duties they are employed to perform.

People who used the service and others were not protected against the risks associated with unsafe or unsuitable premises because of inadequate maintenance.

Is the service well-led?

Inadequate

The service was not well led.

The registered manager had not fulfilled the services regulatory responsibilities and submitted required notifications to the Care Quality Commission.

The registered provider failed to ensure that at least one sign showing their most recent rating by the Commission was displayed conspicuously and legibly on the premises.

The registered provider had not taken all reasonable steps to ensure the financial viability of the service.

The registered provider had failed to ensure records were available in relation to the regulated activity.

Hope Residential Care

Detailed findings

Background to this inspection

We undertook an unannounced focussed inspection of Hope Residential Care on 08 and 11 December 2015. The inspection was done to check that improvements to meet legal requirements planned by the provider after our 16 and 21 July 2015 comprehensive inspection had been made. We also looked at concerns that had been shared with the Commission since that inspection about management on call arrangements, staffing levels and the financial viability of the service. The team inspected the service against two of the five questions we ask about services: is the service safe and well led. This was because the service was not meeting some legal requirements.

The inspection was undertaken by an Adult Social Care Inspection Manager and two Adult Social Care Inspectors. During our inspection we spoke with five staff members, looked at staffing and on call management arrangements, looked at food and nutrition arrangements and looked at the care records of two people. We also undertook a tour of the environment and looked at the financial viability of the service. We asked to view records in relation to the management of the regulated activity.

Inadequate

Is the service safe?

Our findings

During the comprehensive inspection of this service on 16 and 21 July 2015 we found recruitment procedures were unsafe. This was because the registered provider had employed people before appropriate checks had been completed. These checks were required to ensure staff working at the home were safe to work with vulnerable people. This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

During this inspection the recruitment records of one person employed since our inspection on 16 and 21 July 2015 were not available. This meant we were unable to identify appropriate checks had been made to ensure the person was safe to work with vulnerable people. The person was no longer employed by the service so we were unable to discuss their recruitment with them.

We also found whilst reviewing a selection of employment records that one member of staff had been employed without a Disclosure and Barring Service check (DBS) since 2013. The staff member told us they had a criminal record. There was no documentary evidence that the staff member's criminal record had been discussed at interview. The registered provider had not completed a written record prior to offering the staff member employment assessing why they were suitable to work for the service. There was no evidence that an enhanced induction or increased supervision was carried out for this person. These checks were required to identify if people had a criminal record and were safe to work with vulnerable people.

This was a continued breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

We found the service did not have a duty rota confirming how staff were deployed to support the people in their care. All five members of staff we spoke with told us they received a text message each week from the registered provider informing them the hours they had been allocated to work at the home. This meant we were unable identify that appropriate staffing arrangements were in place to meet the needs of people who lived at the home. One staff member told us, "Rotas for staff are given by text messages. There is never a paper copy of the staff rota." We saw copies of employee weekly time sheets. These sheets confirmed the hours employees had worked for payment. The sheets evidenced staff were working alone during periods of their shift.

We found suitable on call arrangements were not in place to support staff working alone in the home. We were told by staff members about occasions when they had been unable to contact the registered provider when they required assistance to support people in their care. This meant people did not always receive the care and support they required when they needed it.

We were told about two occasions when the registered provider was providing on call support and the staff member on duty had been unable to contact them. We were told one staff member had to contact the off duty senior carer for assistance when one person fell and they were unable to lift the person on their own. The staff member said they had made attempts to contact the registered provider without success. The

person was on the floor for half an hour uninjured but unable to get up.

When we undertook this inspection the senior carer providing management cover for the registered provider was due to take leave. The registered provider had been approached by the senior carer to provide cover, but the provider had failed to do so. This meant there was no assurance that the duty rota was covered. In addition staff working alone in the home would not be able to request management assistance in the event of emergencies occurring during their shift if the senior carer took their leave.

A member of staff told us when they commenced working at the home they should have been on duty with the registered provider to complete their induction training. They told us they completed the shift on their own and administered medication to people when they had received no medication training. Suitable arrangements were not in place to ensure people were supported by a staff member who had received appropriate training to enable them to carry out the duties they were employed to perform.

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

We found the falls risk assessment for one person identified as being at medium risk of falling had not been reviewed since November 2014. We saw following the review the person had been referred to the falls matron as they were getting increasingly unsteady and experienced stumbling. There was no record of a new assessment, a review of assessment or any documentation for falls and moving and handling for 2015. This meant the information in the assessment was dated and didn't reflect the person's needs and the level of support they required. There was no information recorded to instruct staff who might be working alone how they would manage the person in the event of them falling. This meant the service was not doing all that was reasonably practical to minimise risks to the health and safety of people in their care.

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

A staff member told us about an incident in November 2015 when they found one person sat on the floor in the lounge. We were told the person had tried to walk without their walking frame, had lost their balance and fallen. The staff member told us they had been unable to contact the person providing on call cover. The person had remained on the floor uninjured for half an hour before assistance was provided by an off duty member of staff. There was no reference to this incident on the person's care records or an accident/incident form completed. There was no evidence this incident had been investigated and the person's care plan updated. This meant the service did not have systems and processes established to effectively protect people from improper care.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

We looked around the building and found neglect and a lack of investment. One room on the ground floor had experienced a flood from the room above. The ceiling and carpet were both damp and there was a strong odour in the room. We found the carpet on the first floor corridor was frayed and a potential risk to people tripping. We saw a carpet rod had lifted and this was a potential hazard to someone tripping. A step on the staircase leading to the first floor was loose and we were concerned people using the staircase could lose their balance and fall. We noted an accident report for a person who had tripped over the hallway step. No injuries were noted.

We also saw furnishings in some bedrooms were in a poor state of repair. We saw a cupboard door to a vanity unit was broken and hanging off its hinges.

We found a bedroom on the ground floor was being used to store the personal belongings of the registered provider. The bedroom door couldn't be closed because the belongings had blocked the door. We were concerned this was a potential fire hazard and requested items be moved further back in the room so the door could be closed.

A staff member told us there had been leaks from the roof in the two bay windows in the lounge when it recently rained heavily. We were told a relative of the registered provider had helped to move the television because it was directly under the leaks and buckets had to be put in place to catch the water. Staff informed us the roof had not been repaired. We were able to see water damage caused to the ceiling.

We found the home did not have a working tumble dryer and people's wet clothing was dried on radiators around the home. This created an unpleasant smell of dampness and was undignified for people who lived at the home. The senior member of staff on duty told us the service had been without a tumble dryer for two months. We were told a replacement dryer had not been purchased despite repeated requests to the registered provider.

Two members of staff told us they had been instructed by the registered provider to leave the heating turned off until 4pm. We were told people were provided with additional clothing and blankets to keep them warm when the heating was turned off.

Maintenance records including gas, fire and electrical installation certificates were not available for inspection. This meant we were unable to confirm these facilities had been serviced and were safe for use. We asked to review the maintenance book for ad hoc maintenance required for the property. One member of staff said, "There was a maintenance and communication book but they kept disappearing." This was confirmed by another member of staff who said, "The maintenance book disappeared and the communication book is missing."

This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Inadequate

Is the service well-led?

Our findings

During the comprehensive inspection of this service on 16 and 21 July 2015 we found the registered provider had not notified the Care Quality Commission (CQC) without delay of the death of a person who lived at the home, allegation of abuse and an application to deprive a person who lived at the home of their liberty. This was a breach of Regulations 16 and 18 of the Care Quality Commission (Registration) Regulations 2009.

We looked at the care notes of one person which showed they had slipped and fallen on a wet floor in the downstairs bathroom on 22 August 2015. The notes said the person had suffered a skin tear to their left arm and had been sent to hospital for an x-ray. The care notes confirmed the person had suffered a fracture to their left arm. The registered provider had not fulfilled their regulatory responsibilities and submitted a notification to CQC about the injury suffered by a person who lived at the home.

We found the registered provider had not fulfilled their regulatory responsibilities and submitted a notification to CQC that an insufficient number of suitably qualified, skilled and experienced persons were being deployed to support people who lived at the home. We identified during the inspection staffing levels provided by the registered provider did not always meet the assessed needs of people who lived at the home.

We identified during the inspection the registered provider had not taken all reasonable steps to ensure the financial viability of the service. This meant they were not achieving the services aims and objectives set out in the statement of purpose and meeting their registration requirements. The registered provider had not fulfilled their regulatory responsibilities and submitted a notification to CQC of an event which prevents, or appears to the service provider to be likely to threaten to prevent, the service provider's ability to continue to carry on the service safely.

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This was a breach of Regulation18 of the Care Quality Commission (Registration) Regulations 2009.

We found the report for the inspection completed on 21 July 2015 was not on display in the home. This meant people who visited the service were not informed about the outcome of the inspection and the rating the service had been given. Registered providers must ensure that at least one sign showing their most recent rating by the Commission is displayed conspicuously and legibly on the premises.

This was a breach of Regulation 20 A of the Health and Social Care Act 2008 (Regulated Activities) 2014.

We found there were no environmental risk assessments available to monitor the safety of the premises. The service did not have a maintenance book to record minor repairs that required attention on the premises. There were no care plan audits available to monitor and mitigate the risks to people's care delivery. We found records were not available in relation to the management of the service including utility certificates confirming the premises were a safe environment for people to live. Records relating to person's employed by the service including recruitment records were also unavailable for inspection.

This was a breach of Regulation 17 of the Care Quality Commission (Regulated Activities) 2014. Regulations 2009.

After the inspection took place the registered provider made the decision to close the service.