Shadowsource Limited

Eaton Court Residential Home

Inspection report

128-130 Grove Road
Wallasey
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23 September 2016

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Ratings

Overall rating for this service	Requires Improvement
Is the service safe?	**Requires Improvement**

Summary of findings

Overall summary

We carried out an unannounced focused inspection of this service on 23 September 2016. This inspection was carried out following several whistle-blowers coming forward about the service. The allegations were that the building where people lived, was not of an acceptable standard. People who used services and others were not protected against the risks associated with unsafe or unsuitable premises because of inadequate maintenance. The concerns also alleged there were not sufficient numbers of suitably qualified staff to meet people's requirements safely. We found that this was the case and that there were breaches of Regulations 15 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

Eaton Court Residential Home is situated in a residential area of Wallasey, close to local amenities and transport. There is parking to the front of the property and a small garden to the rear. It provides accommodation for up to 26 persons who require personal care. There were 13 people living in the home at the time of our inspection. The service employed 19 staff including the registered manager and the financial manager.

The home required a registered manager. 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 in the Health and Social Care Act 2008 and associated Regulations about how the service is run. There was a registered manager in post but they were on holiday at the time of this inspection. The financial manager was in attendance.

We observed that staffing levels were a concern as we saw that staff were providing care for people who were in bed or dealing with visiting professionals leaving the rest of the home with no care support. Feedback from staff, relatives/visitors also confirmed that they felt there was a problem.

We saw the premises were in need of redecoration and some areas had been placed 'out of bounds' due to disrepair. We also saw that water temperatures were not regulated in some communal areas of the home. For some weeks we found that a bath chair had been out of commission which meant that some people had not been able to access bathing facilities.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not safe

There were insufficient staff to safely meet the needs of the people living in Eaton Court.

The premises were shabby and in need of repair with ripped wallpaper and chipped paintwork.

There were insufficient bathing facilities for people living at Eaton Court.

Eaton Court Residential Home

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 was 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.

Prior to the inspection we had been informed of concerns via the local authority and a whistle-blower regarding staffing at Eaton Court. We also received information of concern regarding premises and broken equipment.

We carried out an unannounced focused inspection of Eaton Court on 23 September 2016. This inspection was carried out by an adult social care inspector.

We observed care and support for a number of people who lived at the home. We reviewed a range of documentation including care plans, personal evacuation plans, staff training records, and other records relating to how the home is managed.

Requires Improvement

Is the service safe?

Our findings

We were able to speak with staff and relatives who didn't think there were enough staff on duty. One person said "I think the problem's that there's not enough staff".

Prior to the inspection information had been received from a whistle blower that there were insufficient staff to safely meet the needs of the people living at the home. We observed that there were two care staff on duty and we asked for copies of the rotas for the previous month and saw that only two staff were routinely scheduled to work on shift. There were three people being cared for in bed who needed regular attention and each needed two staff at a time, to meet their needs. This meant that when staff were attending to these people there was no support for the rest of the people living in the home. We looked at the personal evacuation plans for the people living in the home and saw that the majority of people needed the help of either one or two staff to help with mobility/transfers from chair to chair.

We were told that menus had needed to be changed due to staffing. If the cook left at an early time and there were certain foods on the menu then care staff had to take over food preparation and cooking.This meant there was a shortage of care staff to adequately support the people who lived in the service.

During our inspection we saw a health care professional visiting a person who lived in the home. One staff member had to attend the appointment which left one care worker to care for people in bed and in the communal areas. We also observed a medication round and saw that even though the staff member tried to inform people who asked for help that she was administering medication, the staff member had to leave the medication trolley to help a person with mobility issues. The other staff member on duty was already attending another person. This were insufficient and unsafe staffing for the needs of the people living in Eaton Court.

We saw that an activities timetable was on the wall. We asked if the activities scheduled, too place and we were told only when the staff had the time. There was no activities co-ordinator employed. This meant that people living in the home did not have regular access to any pastime/hobbies they may enjoy.

We looked at peoples files and saw risk documents that included moving and handling assessments which stated that two staff were needed to support a person. We also saw repositioning charts which stated that two staff were needed to ensure safe use of equipment when manoeuvring a person being cared for in bed.

These examples were breaches of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

On our tour of the building we saw notices on doors saying the facilities were out of bounds. For example, we saw 'do not use bath' and 'do not use toilet'. This toilet had been out of commission since the last CQC inspection that had been carried out in 2014. We noted that the bath seat had been out of commission for two weeks, this had not been actioned until the financial manager had returned from holiday who then purchased one from an internet based shopping website. We were assured that this equipment was to be

checked and serviced by an external maintenance company. We saw that four bedrooms that were in use were en-suite with showers. The other people in the home had only had access to one communal shower and no opportunity to have a bath in the time the equipment had been broken. We saw another bathroom that was used to clean commodes, not for use by the people who lived in the home

We observed that doors had been wedged open, as these were fire doors this meant that this was unsafe practice. The wallpaper was seen to be peeling off some of the walls, paintwork was chipped which showed the home had not been maintained for some time. This meant that the building was difficult to keep clean. We looked at the hours the maintenance person worked and saw that this was 12 hours a week, on looking at the environment this was obviously not sufficient for the upkeep of the premises.

On our tour of the building we saw warning signs above sinks warning of the risk of hot water. We asked if the hot water was regulated in the home and we were told only a few rooms had these safety measures in place. This meant that any person with any sight issues, other health problems or dementia was at risk of not being able to see or understand the warning and scalding themselves. We spoke to the maintenance person who was on site and we followed this by contacting the registered manager so this issue could be addressed.

These examples were breaches of Regulation 15 of the 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 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 15 HSCA RA Regulations 2014 Premises and equipment People who used services and others were not protected against the risks associated with unsafe or unsuitable premises because of inadequate maintenance and provision of equipment.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were insufficient numbers of suitably qualified, competent, skilled and experienced persons deployed in order to meet the requirements of the people who use the service.