Independent Care Initiatives

Strathallen

Inspection report

6 Albion Terrace, Saltburn By The Sea, TS12 1JN
Tel: 01287 622813
Website: www.example.com

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Overall summary

A comprehensive inspection took place at this service on 18 December 2014. At this inspection a breach of legal requirements was found. People who used the service and others were not protected against the risks associated with unsafe care because effective systems were not in place to ensure that regular auditing was undertaken. No analysis of accidents and incidents had been carried out. Audits had been carried out randomly and audit records were confusing and disorganised. Audits of the environment had been carried out. A health and safety audit had not been carried out, this meant that fire alarm testing and water temperature checks had not been completed and could have been identified if an audit had have been carried out.

The registered provider wrote to us telling us what action they would be taking in relation to the breach. As a result we undertook a focussed inspection on 20 July 2015 to follow up on whether action had been taken in relation to the breach.

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

Strathallen provides care and accommodation for up to nine adults who have a learning disability. The service is located centrally in Saltburn and is very close to local amenities.

The service does not require a registered manager. The registered provider manages and works at the service on a day to day basis. 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.

At this focussed inspection on 20 July 2015 we found that the registered provider had followed their plan and legal requirements had been met. This was an unannounced visit which meant the staff and provider did not know we would be visiting.

We could see that improvements had been made to audits at the service. Audits had been carried out more regularly. This meant that service had been able to improve the levels of quality assurance.

Accidents and incidents which had occurred at the service had been recorded. No analysis of these had been carried out. This meant that we could not see if any patterns or trends had been identified and where appropriate action taken to minimise the risks to people who used the service. We highlighted this at our last inspection. When we looked at the records, we could see patterns between the types of accidents and incidents and the people involved.

Audits for medicines had been carried out and we could see medicine reviews for all eight people who used the service had been completed since our last inspection.

Summary of findings

Care plan and health action plan audits had been carried out regularly. We could see that changes had been made to increase the quality of these audits. There were some gaps in these audits which we highlighted to the deputy manager.

An infection control audit showed that the home was clean and had appropriate arrangements in place to maintain the prevention of infection control and to keep people safe. Mattresses were checked to make sure they were clean and safe for use. A hand washing audit needed further improvements to ensure it was effective in monitoring the quality of hand washing procedures carried out by staff.

A health and safety audit showed that the service had kept up to date with checks of fire alarms and exits ad that regular fire drills had been carried out. The audit showed that certificates required for the health and safety of the building, such as gas boiler checks were up to date and checks of water temperatures had been checked. We could see that water temperature records showed that they were not always within the correct water temperature limits. Some temperature checks were below 43 degrees Celsius.

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?

Is the service effective?

Is the service caring?

Is the service responsive?

Is the service well-led?
The service was well-led.

Audits were in place and were carried out regularly, however gaps in the records were identified. Accident and incidents at the service were recorded, but analysis of these to highlight patterns and trends had not been carried out.

Strathallen

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 checked 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.

A comprehensive inspection carried out 18 December 2104 identified a breach of regulations. A focused inspection carried out 20 July 2015 looked at the action the registered provider had taken in relation to the breach of legal requirements we found on 18 December 2015. You can find full information about our findings in the detailed findings sections of this report.

The inspection team consisted of one adult social care inspector.

We inspected the service against one of the five questions we ask about the service: Is the service well-led. Before the inspection we reviewed all the information we held about the service. During the inspection we spoke with three people who used the service. We also spoke with the registered provider, deputy manager and a senior support worker. We looked at records related to the management of the service.

Is the service safe?

Our findings

Is the service effective?

Our findings

Is the service caring?

Our findings

Is the service responsive?

Our findings

Is the service well-led?

Our findings

At the last inspection we found that the registered person had not protected people against the risks associated with unsafe care because effective systems were not in place to ensure that regular auditing was undertaken. This was in breach of regulation [10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At out last inspection we saw that audits and checks had been undertaken, however improvements were needed. We saw that audits had been undertaken randomly. Records of these audits were confusing and disorganised. There were no set timescales, for example monthly. Although health and safety was covered generally in some of the audits there were some areas that had been missed. It was felt that a health and safety audit could have been of benefit to the service. Previous audits had failed to pick up on gaps in the testing of water temperatures and that records to confirm testing of the fire alarm were missing. Also there was no analysis of accidents and incidents to identify patterns and trends at service.

At this inspection we looked at accident and incident records at the service. We could see that accidents and incidents had been recorded and where appropriate referrals to the local authority safeguarding team had been included. There were also details about each accident and incident; however we found further improvements were needed. There was no analysis about accidents and incidents occurring at the service. This type of information could have identified patterns and trends which meant that the service could take action to reduce the risks to people using the service. From the records, we could see some patterns between one person involved and the type of accidents they had been involved in. We spoke to the deputy manager to discuss whether a risk assessment was needed for this person.

We could see that the service had made changes to the information collected during the audits and the frequency of which they were carried out. A medicines audit had been completed each month. Actions for training had been addressed and medicine reviews for people who used the service had been completed. A health action plan audit had been re-written to increase its effectiveness. This meant that more appropriate information could be collected. We could see that the health and well-being of all eight people who used the service had been regularly reviewed. We did see some gaps in the records for two people where a health action plan audits had not been fully completed. We could see that care plan audits had been carried out each month; this meant that the quality of care records for people who used the service had been monitored appropriately.

An infection control audit had been put in place in April 2015 and had been completed each month. We could see that personal protective equipment was in place and cleanliness, staff appearance and training had been checked. A hand washing audit had been put in place and had been carried out each month, however we could not see if staff had been shown the infection control and prevention procedure for carrying out hand washing or if they had been observed carrying out the appropriate hand washing procedures. The deputy manager told us about the plans they were putting in place for hand washing training. A mattress audit was carried out twice per year on all mattresses at the service and visual checks were carried out weekly. This meant that the service was monitoring the quality and cleanliness of mattresses to ensure that there were safe for use by people who used the service.

At the last inspection we could see that health and safety was covered generally in other audits, but no specific health and safety audit had been in place. At this inspection we could see that a health and safety audit was now in place and had been carried out each month [excluding March 2015]. The audit showed regular fire alarm testing had been carried out. This audit ensured the service kept up to date with fire drills and checks of emergency exits and lighting. We could see that training in health and safety was up to date. We could also see that taps and water temperatures had been checked, however from the records we could see that some water temperatures were below the Health and Safety Executives guidance of 43 degrees Celsius.