Heltcorp Limited

Goole Hall

Inspection report

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Ratings

Is the service safe?	Requires improvement
Is the service well-led?	Requires improvement

Overall summary

We carried out an unannounced comprehensive inspection of this service on 27 November 2014. In October 2015 we received information of concern and, in addition to this, the local authority shared information with us following a quality monitoring visit they had made to the home. We carried out a focused inspection to look into the concerns we had received. This report only covers our findings in relation to those concerns. You can read the report from our last comprehensive inspection by selecting the 'all reports' link for Goole Hall on our website at www.cqc.org.uk.

This inspection took place on 9 November 2015 and was unannounced.

The service is registered to provide accommodation for a maximum of 28 people, some of whom are living with a dementia type illness. Most people are accommodated in single rooms and some have en-suite facilities. The property is a listed building and is located within its own grounds close to the town of Goole, in the East Riding of Yorkshire.

The registered provider is required to have a registered manager in post and on the day of the inspection the manager who was employed at the home was not registered with the Care Quality Commission (CQC). 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.

During our inspection we identified two breaches in regulations. This related to the safety of the premises and

Summary of findings

the lack of quality auditing to ensure the premises were safe for the people who lived there. You can see what action we told the provider to take at the back of the full version of the report.

The reporting of serious incidents in the service was not robust; there had been a delay in the home notifying us of some serious incidents.

An environmental risk assessment had been completed but this did not identify areas of potential risk to people using the service and did not include an assessment of all areas of the home. Risk assessments and documentation in respect of people who lived at the home required updating to show the current needs of people who used the service.

The records we looked at in respect of the risk of malnutrition and tissue viability were seen to be complete and monitoring records in respect of food and fluid intake and positional changes were being completed consistently.

Although accidents had been recorded accurately, there was little evidence of consultation with health care professionals to check that people had not been injured, and the auditing of accident records was behind schedule. We have made a recommendation in the report in respect of this shortfall.

We saw that there were sufficient numbers of staff on duty. However, the manager was regularly required to work as senior care worker or care worker due to staff vacancies and this meant they were not able to manage the home effectively.

Audits of care plans had not been carried out, resulting in information in some care plans not being up to date. This meant that staff did not always have current information about a person to ensure they received optimum care and support.

We found that there were unpleasant odours in some communal areas of the home and that the laundry room required attention to reduce the risk of the spread of infection. We have made a recommendation in the report in respect of this shortfall.

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?

Requires improvement

The service was not safe.

The environmental risk assessment had not identified some areas of risk within the home. Risks associated with people's care had not been updated to reflect their current care and support needs.

Accident records were accurate but there had been little consultation with health care professionals following accidents, and auditing of accidents was behind schedule.

The home was being cleaned regularly but one carpet needed to be replaced and laundry facilities needed to be improved to reduce the risk of the spread of infection.

Is the service well-led?

Requires improvement

The service was not well-led.

The manager was not registered with the Care Quality Commission.

Quality audits had not been carried out consistently so care plans and health and safety issues had not been identified and addressed.

There had been a delay in notifications being submitted to the Care Quality Commission.

Goole Hall

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 is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008 and to look at the overall quality of the service.

This inspection took place on 9 November 2015 and was unannounced. The inspection was undertaken by one inspector.

Prior to the inspection we spoke with the safeguarding adult's team and the quality monitoring team of the local authority who commissioned a service from the home. We did not request a provider information return (PIR) on this occasion as one had previously been requested in preparation for the inspection in November 2014. The PIR is a document that the registered provider can use to record information to evidence how they are meeting the regulations and the needs of people who live at the home.

On the day of the inspection we spoke with one person who lived at the home, two members of staff, the manager, the regional manager and the registered provider. We checked the care records for two people who lived at the home, accident / incident records, quality monitoring records and environmental risk assessments. We also toured the premises to assess safety and cleanliness.

Requires improvement

Is the service safe?

Our findings

Prior to this inspection we received information of concern about environmental risks, low staffing levels, safeguarding procedures and risk assessments for people who lived at the home. We checked these areas of concern during our inspection of the home on 9 November 2015.

We checked the care plans for two people who lived at the home and we noted that falls risk assessments had been completed. However, we saw that the falls risk assessment for one person recorded "Due to poor mobility and health, appears prone to falls" but that the risk was stated to be 'low'. We noted that one risk assessment had not been updated following the person having several falls. This meant that there was no accurate record of the risks involved in a person's care, which could have resulted in them not receiving the correct level of support.

We saw that one person's care plan included information about them having regular falls although we noted that their patient passport did not record that they were at risk of falling. Patient passports are documents that a person can take to hospital appointments or admissions when they are unable to verbally communicate their needs to hospital staff. This meant that hospital staff would not have had full access to information about this person's individual care and support needs.

We checked two care plans on the day of this inspection and noted that one person had a nutritional risk assessment in place as they had been identified as being at risk of malnutrition. The risk assessment recorded that care staff had consulted a dietician for advice about how to reduce this risk. The dietician had recommended that the person's drinks needed to be thickened and when we spoke with staff on duty they were able to explain to us how this person's drinks were prepared to make them safe for the person to drink. We saw the charts that recorded the person's weight, food and fluid intake and positional changes and noted these were being completed consistently.

We checked accident records and saw that accident forms had been completed accurately and included the use of body maps. There were some advice documents held with accident records. This included information about managing falls and fractures in care homes for older people and information on drugs that could cause sedation, confusion, low blood pressure and lead to falls. However, we noted that, of the nine accidents that occurred in August 2015, no medical attention was deemed to be necessary for seven accidents and in-house first aid was administered for the other two accidents. The accident forms included comments such as, "Checked over – seemed fine" and "No injuries." This meant that staff had made the decision that people did not require medical attention without seeking appropriate advice.

We recommend that the registered provider considers how health care professionals are involved in managing a person's care and treatment.

Accident records were accompanied by body maps. These were used by staff to identify where on the body any injury had occurred and included the date the injury had occurred and the name of the staff member making the entry. These records helped staff to monitor a person's recovery following a fall.

Accident records had been audited up to August 2015. The analysis of accident records included the type of accident, the time and place of the accident and a record of any assistance or treatment that was required. The accident records for September and October 2015 were held in a separate folder; the manager told us that this was because they had not yet been audited. We saw that these records included body maps and that medical attention had been sought following two of these falls.

Because we had concerns about the safety of the premises, we checked the environmental risk assessment. This included information about the safety of the main stairs in the home. It recorded, "Consequence of hazard – falls, trips and slips. Current control measures – all residents are assessed at climbing and descending the staircase. This is kept in care plan. Staff to assist and observe as and when needed. Diversional barrier in place to discourage confused and / or disorientated service from mounting the stairs." This risk assessment was completed on 13 February 2015 and recorded that a review was due on 13 August 2015, but we saw that the review had not taken place. The 'side' stairs of the home where a recent accident was thought to have occurred were not assessed as part of the environmental risk assessment. This meant that there had not been an effective assessment of all areas of the home that would protect people who lived at the home and staff from the risk of falls.

Requires improvement

Is the service safe?

Since the suspected accident, a gate had been fitted to the bottom of the stairs. Gates had also been fitted to the top and bottom of another staircase at the home. However, this had been actioned following the suspected accident rather than as a result of this risk being identified as part of a health and safety assessment.

This was a breach of Regulation 12 (1)(2)(d) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014 which states the premises used by the service provider must be safe for use and used in a safe way.

On the day of this inspection we saw that there were three care staff on duty, plus a domestic assistant and a cook. We observed that people received the attention they required and that emergency call bells were responded to promptly. Although there was no dependency tool being used to determine staffing levels, we considered that there were sufficient numbers of staff on duty to meet the needs of the people who lived at the home. However, we noted that the manager was one of the staff on duty; they were working as a senior care worker rather than the manager. Staff rotas evidenced that this happened on a regular basis. This meant that the manager was not able to carry out the management tasks that were needed to ensure the home was running in a safe and effective way.

In addition to care staff and ancillary staff, there was an activities coordinator on duty each Monday, Wednesday and Friday afternoon; on the day of the inspection we saw that they encouraged people to take part in activities and that activities were taking place.

We checked a sample of alerts that had been submitted by the home to the local authority in respect of safeguarding incidents at the home. We saw that alerts had been completed correctly and that one alert in respect of a person who had fallen recorded, "Referred to Falls team. Review of medication, blood tests and ECG test." This evidenced that on this occasion appropriate action had been taken following the fall to check for any underlying health concerns that could be causing the person to fall.

Staff had completed training on safeguarding adults from abuse although refresher training was due to take place for some staff. The manager acknowledged this and told us about the arrangements they were making for staff to have additional training.

On the day of the inspection we noted that there were malodours in the entrance hall and main lounge of the home. We discussed this with the registered provider who acknowledged that the carpet in the main lounge needed to be replaced.

However, we saw that the communal areas of the home, bedrooms, bathrooms and toilets were maintained in a clean and hygienic condition. Two domestic assistants were employed at the home and there was a domestic assistant on duty each day. On one day a week, both domestic assistants worked together to 'deep clean' areas of the home. We spoke with one of the domestic assistants and they showed us the cleaning schedules; these evidenced that all areas of the home were cleaned on a regular basis.

We saw that bathrooms and toilets contained paper towels, hand wash liquid and hand steriliser rather than soap and towels; this reduced the risk of the spread of infection.

All but one member of staff had completed training on the control of infection, although refresher training was overdue. There was a policy in place on the control of infection and we saw that an infection control audit had been carried out in August 2015. This recorded some improvements that needed to be made, such as "Awaiting window cleaner" and the action plan recorded, "Windows now cleaned." This showed that some shortfalls in cleanliness had been addressed.

Staff from the local authority had been told that the kitchen fridge was not clean and they found this to be the case when they carried out their checks. On the day of this inspection we checked the fridges in the home's kitchen and had no concerns about cleanliness.

We noted that the laundry room was small and difficult to divide into 'clean' and 'dirty' areas, although efforts had been made to define these areas. The paint on one wall was flaking and this made the wall difficult to keep clean. The layout of the room meant that it was difficult to ensure that there was no spread of infection from soiled items to clean items. We saw that there was a supply of personal protective equipment (PPE) for staff in the laundry room as well as suitable hand washing facilities. However, we saw that there were some cleaning products and toiletries stored in the room and the door was not locked. This

Requires improvement

Is the service safe?

meant there was a risk that people who lived at the home could ingest chemicals by accident and be harmed. The staff member who we spoke with told us they would ensure these products were stored elsewhere.

We recommend that the registered provider considers current guidance on the prevention and control of infections, in relation to the laundry facility and other areas of the service.

Requires improvement

Is the service well-led?

Our findings

We had received information prior to the inspection that the manager was not being given the opportunity to manage the home and we checked this during the inspection on 9 November 2015.

On the day of this inspection the service had a manager in post who was not yet registered with the Care Quality Commission. However, following the inspection the manager informed us that they had commenced the registration process on 19 November 2015.

Services that provide health and social care to people are required to inform the Care Quality Commission (CQC) of important events that happen in the service. The manager of Goole Hall had informed the CQC of accidents and incidents at the home although there was a delay in CQC receiving some recent notifications. The information we had received from the local authority indicated that they had to advise the manager to submit a notification to CQC. However, the manager told us that the delay was because they had experienced IT difficulties.

We had received information indicating that the manager had not been given the opportunity to properly manage the service, and we found this to be the case on the day of this inspection. This was acknowledged by the registered provider. There were staff vacancies at the home and this meant that the manager was covering care worker and senior care worker shifts instead of carrying out management duties. For example, during week commencing 2 November 2015 the manager had worked three days until 2.00 pm and one full day to cover care shifts; this was out of the five days she worked. There was no evidence that the registered provider had considered employing agency staff to cover care shifts so the manager could manage the service.

Because the manager had been working care shifts each week, quality monitoring at the home was behind schedule. We did not check this in any detail as it was agreed by the manager, the regional manager and the registered provider that all quality audits needed to be updated. This meant that there had been a lack of opportunity for people who lived at the home, staff, relatives and health care professionals to give feedback to the registered provider about the quality of the service being provided, and meant there was a lack of opportunity for learning and to make improvements to the service.

One health and safety audit had been carried out during 2015. This included a check on the stairs and included questions about lighting, cleanliness, lack of obstructions and presence of handrails that were needed to make the stairs safe. However, this audit related to the main stairs of the home and not the 'side' stairs. There was no mention of the 'side' stairs in the health and safety audit. This meant that some areas of the home had not been assessed to identify if there were any risks to the safety of people who lived and worked at the home.

Records in care plans were detailed and included information that helped staff to get to know the person, such as their daily routines and their life history. One of the care plans we saw had been updated appropriately. However, another person's care plan recorded that they were not at risk of falls when accident records showed they had numerous falls over a three month period. This meant that staff did not always have up to date information to follow and this put the person at risk of harm. More robust auditing would have identified that not all care plans were up to date.

This was a breach of Regulation 17 (2)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014 which states that there must be systems established and operated to assess, monitor and improve the quality and safety of service users.

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 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: Care and treatment had not been provided in a safe way for service users due to inadequate risk assessment of the environment. Regulation 12 (1) (2) (d).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: Systems had been established but were not being operated to assess, monitor and improve the quality and safety of the service. Regulation 17 (2) (a) (b).