Haldane House Limited

Haldane House Nursing Home

Inspection report

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Ratings

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

Summary of findings

Overall summary

At the comprehensive inspection of Haldane House Nursing Home on 8, 10 and 13 June 2016 we identified six breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (HSCA). We issued the provider with two warning notices and four requirements stating they must take action to address these breaches. We shared our concerns with the local authority safeguarding team.

This focused inspection was carried out to assess whether the provider had taken the necessary actions to meet the warning notice we issued in relation to Regulation 12 (HSCA) which relates to safe care and treatment. We will carry out a further inspection to assess the actions taken in relation to the second warning notice and the four requirement notices and to provide an overall quality rating for the service.

This report only covers our findings in relation to the warning notice we issued with regard to Regulation 12 (HSCA) and we have not changed the ratings since the inspection in June 2016. The overall rating for this service is 'Requires Improvement'. You can read the report from our last comprehensive inspection by selecting 'all reports' links for Haldane House on our website at www.cqc.org.uk.

Haldane House is a care home with nursing. It provides accommodation and nursing care for up to 25 people. Some of the people using the service are living with dementia. At the time of our visit there were 24 people living there.

The home is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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 the time of the inspection there was a registered manager at the service and they assisted with the inspection.

At this inspection we found the provider had taken action to address the issues highlighted in the warning notice. The provider and registered manager had submitted a comprehensive action plan to address the breaches of regulations.

During our last inspection we found that risks assessments had not always been completed. People's care and support plans did not always contain safe systems of work or detailed information for staff to follow in order to minimise risks. At this inspection risks assessments had been reviewed and updated to contain guidance for staff on how to minimise the risk of harm to people.

At our last inspection we found not all staff had received up to date training in moving and handling people. We could not be sure if training included practical as well as theoretical training. At this inspection the training certificates clearly indicated the practical elements of the training provided as well as the theory. All staff had received appropriate training and the provider had installed a new computerised system to record all training and alert managers when refresher training was required.

Staff were confident in their approach to assisting people to move or transfer and used appropriate techniques to promote people's safety. The registered manager and senior staff worked alongside staff to promote best practice and provide guidance for care staff.

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

We found that action had been taken to improve safety. However, we could not improve the rating for safe from inadequate because to do so requires consistent good practice over time. We will check this during our next planned comprehensive inspection.

Risk assessments were carried out and safe systems of work developed to minimise risks.

Staff had received appropriate training to minimise the risks associated with moving people.

Haldane House Nursing 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 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.

We undertook this focused inspection of Haldane House Nursing Home on 11 October 2016. Following the comprehensive inspection on 8, 10 and 13 June 2016, we issued warning notices and asked the provider to take action within a given timescale to make improvements. This focussed inspection was completed to ensure those improvements to meet the legal requirements had been completed. We inspected the service against one of the five questions we ask about the services: is the service safe?

The inspection was carried out by one inspector and was unannounced.

During our inspection we spoke with the provider, the registered manager, the deputy manager and a care worker. We reviewed records which included four care and support plans and associated risk assessments. We also looked at monitoring documents, training certificates and the staff training matrix. We made general observations of staff providing support to people and interacting with them.

Inadequate

Is the service safe?

Our findings

At the previous comprehensive inspection of Haldane House which took place on 8, 11 and 13 June 2016 we found that risk assessments had not always been completed for people. Where this was the case there were no safe systems of work available for staff to follow. Those care plans which did contain risk assessments had not been regularly reviewed and did not contain sufficient detail to ensure staff had guidance to keep people safe.

People did not always receive safe care when they needed assistance with moving or transferring. Staff were unsure of how to assist some people to move safely. The training records in relation to moving and handling people showed not all staff had up to date training and it could not be established from the records if training had included practical as well as theoretical training.

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

At this inspection we found there had been improvements made. The registered manager explained that all risks assessments were now reviewed every month and when necessary amendments were made. Risks such as those relating to moving and transferring, poor nutritional intake, and developing pressure ulcers had been assessed. Risk assessments contained information on how staff should support people to reduce the risk of harm occurring. For example, one person's care plan contained information stating the person required the assistance of two staff and a piece of equipment when they needed to stand up from a chair. Another detailed how staff should support a person by placing their hand behind the person's waist when assisting them.

One person had a risk assessment relating to the use of bed rails and the position of their bed due to a risk of falling. This had clear detail of how the bed rail should be fitted, the checks staff should make and the reasons for the use of the bed rails. It included the regularity of checks to be made on the person when the bed rails were in place to ensure their safety. Staff recorded these checks on a chart in the person's room.

The risk assessments fed into safe systems of work that minimised identified risks in the least restrictive way possible. Alternative actions were considered and recorded, for example, where bed rails were being used, crash mats and a low bed had been tried first.

Staff training had been reviewed and moving and handling training was provided by a trainer with appropriate qualifications who was employed by the provider. They had reviewed the training and provided clear certificates detailing the theoretical and practical training undertaken by staff. The training matrix showed all staff had completed up to date training on moving and handling people safely.

The provider told us they had invested in a new computerised system which would record staff training more precisely and indicate when refresher training was due. They told us this would prevent training becoming out of date and the management staff were currently receiving training in order to use this system

effectively.

The registered manager told us they and the senior staff worked closely with the care staff. This provided regular opportunities to observe how they worked with people and to guide them in best practice. However, they planned to introduce formal competency testing for staff as part of the annual appraisal process. They said this would include direct observations of staff completing tasks such as moving and positioning people as well as giving personal care.

During the inspection we saw staff supporting people to move using appropriate techniques and equipment. Staff approached this with confidence and demonstrated an awareness of ensuring people's safety.