Bupa Care Homes (CFHCare) Limited

Saltshouse Haven Residential and Nursing Home

Inspection report

71 Saltshouse Road
Hull
North Humberside
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Tel: 01482706636

Date of inspection visit:
30 November 2015

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Ratings

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

Summary of findings

Overall summary

Saltshouse Haven is registered with the Care Quality Commission [CQC] to provide care and accommodation for a maximum of 150 people who have nursing needs or may be living with dementia. The location is separated into five independent units across the site. It is located on the outskirts of Hull and has good public transport access. It is close to local shops and other amenities.

This inspection was unannounced and undertaken on 30 November 2015 in conjunction with the local authority contract compliance team as a result of information received which gave rise to concerns about staffing levels on Sutton lodge which is one of the five units. We had previously inspected the whole of the location in September 2015; it was rated as inadequate overall and placed into special measures. Part of special measures does mean the service can be subject to further inspections if we receive any information of concern. The findings of this inspection have not changed the service's overall rating.

The inspection focussed on Sutton lodge only. This lodge provides care and accommodation for people who need support and are living with high levels of dementia. We did not review any of the other lodges as this will be done when we return to undertake a full inspection of the service to establish compliance with the requirements set at the last inspection in September 2015.

We found staff were not deployed, lead effectively or provided in enough numbers to ensure people were safe or their needs were effectively met on Sutton lodge. Other agencies are now providing a support service to the location to ensure people's needs are effectively met and they are safe. This was with the agreement of the registered provider. This will be for a limited period and we will review the situation in due course and consider whether we need to take further enforcement action.

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 continues to be unsafe on Sutton lodge.

Staff were not provided in enough numbers to meet the needs of the people who used the service.

Rotas did not reflect the staff who were on duty.

Saltshouse Haven Residential and Nursing Home

Detailed findings

Background to this inspection

Start this section with the following sentence:

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 registered provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008. We did not review the rating as the service is rated as inadequate and currently in special measures.

The inspection was undertaken by one adult social care inspector and two local authority contracts compliance officers.

We used the Short Observational Framework for Inspection [SOFI]. SOFI is a way of observing care to help us understand the experiences of people who could not talk with us.

We spoke with five members of staff including nursing staff. We looked at rotas and the contract compliance officers looked a selection of care files. We also undertook a tour of Sutton Lodge to check the environment for cleanliness.

Inadequate

Is the service safe?

Our findings

We found there was not the amount of staff on duty which was indicated by the rota. For example one member of staff had rung in sick and had not been replaced. The nurse on duty was not the one who had been identified on the rota. The acting manager later told us the nurse who should have been on duty had secured a permanent job elsewhere and had not turned up for duty. The two nurses in charge of the unit were agency nurses; they had worked on the unit before and showed a good understanding of people's needs. There was a lack of coordination and no one was willing to take responsibility for ensuring the right amount of staff were on duty to effectively meet people's needs.

When we first arrived at 08:30am on the unit a lot of the people were still in bed and staff seemed to be going about their duties in an effect organised manner. However, as the inspection progressed the staff told us they had to leave some of the people who used the service in bed. They told us as there were not enough staff on duty to meet their needs and to supervise them it was a safer option, despite only two of the people needing to be nursed in bed due to their needs. We saw that people were left in bed until after lunch time.

We also found turn charts and fluid charts had not been completed and other essential information had not been recorded, again staff attributed this to lack of time and staffing levels. One of the members of staff showed us how they had recorded what they had done on their shift up to the time we spoke with them. They produced scraps of paper from their uniform pockets upon which they had written all their duties and notes about the welfare of the people who used the service. They told us they intended to update people's files when they had an opportunity but had been too busy.

We looked at the incident log and found there a number of unwitnessed incidents over the weekend, these ranged from falls to physical altercations between people who used the service. When we asked the staff to describe what had happened in one particular incident they told us they had been in a different part of the unit and had found the person sat by the side of their chair when they came into the lounge. They could not tell us how long the person had been on the floor or how the accident had happened. We saw that entries had been made in the person's daily notes about the incident and that the person had suffered no ill effects from the unwitnessed fall.

Since the inspection the service is being supported by the local Clinical Commissioning Group and district nursing staff are visiting daily to ensure people's safety. We have also formally asked for information about actual staffing levels and the competency of agency nurses used.

The service continues to be subject to special measure and a further inspection will be carried out to check compliance with the requirements set at the last inspection.