Mrs Sally Roberts & Jeremy Walsh

Culworth House Care Home with Nursing

Inspection report

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Ratings

Overall rating for this service	Inspected but not rated

Is the service safe?	**Inadequate**

Summary of findings

Overall summary

We carried out an unannounced focussed inspection on 7 December 2016 as we had received information of concern that suggested the premises were unsafe and put people's health, safety and wellbeing at risk.

Culworth House Care Home with Nursing is registered to provide accommodation for people who require nursing and personal care for up to 35 people. At the time of this inspection there were 19 people living at the home.

There was not a registered manager in post as they had recently left the service. 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. The service was being supported by interim managers until a permanent replacement could be recruited.

The provider had not taken sufficient or prompt action to ensure that the home and the environment were safe.

We found that the only lift in the home was out of order and sufficient action had not been taken to maintain people's mobility and freedom within their home. A majority of people were unable to easily or safely access the ground floor, the communal areas or leave the building unless in an emergency.

We found that roof tiles on the home had been dislodged or were missing. One roof tile was caught in the guttering which posed a risk to people in the outdoor environment. No risk assessment had been made with regards to the state of the roof.

Rain leaked through the roof on the top floor of the home and had caused water damage to a smoke detector. This was a recurrent issue that had not been rectified sufficiently. There had not been a detailed assessment to ensure the integrity of the electrics as a result of this.

The guttering on the roof was inadequate with many parts missing or incorrectly fitted. Plants were growing within the gutters and there was evidence of water damage from the lack of maintenance of the guttering.

The stone chimneys were of a significant age and were in a state of disrepair. No assessments had been made to ensure they did not present a risk to people, or further damage to the building.

The call bell system on the top floor was not fit for purpose as people were unable to call for help from staff that could be nearby.

We relayed our findings on the day of the inspection to the provider. The provider made a decision following

our inspection they would close the home, citing that they did not have the finances available to take all the action required. However we required the provider to take a range of actions to protect the safety of people in the home during the closure process.

This was a breach of Regulation 15 (1) (c) (e) and Regulation 17 (2) (b).

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 provider had not made sufficient or prompt arrangements to ensure the premises were safe for people.

Culworth House Care Home with Nursing

Detailed findings

Background to this inspection

We undertook an unannounced focussed inspection of Culworth House Care Home with Nursing on 7 December 2016. This inspection was completed in response to concerns about the safety of the premises and the environment. As a result we undertook a focused inspection to look into those concerns. This report only covers our findings in relation to those topics.

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.

This inspection was completed by two inspectors. Before the inspection we reviewed the information we held about the service, including statutory notifications that the provider had sent us. A statutory notification is information about important events which the provider is required to send us by law. We also contacted health and social care commissioners who place and monitor the care of people living in the home.

During our inspection we spoke with ten people who lived at the home, two members of care staff, one member of domestic staff, the maintenance manager, the deputy manager, the temporary acting manager, the area manager and the provider.

Inadequate

Is the service safe?

Our findings

Prior to our inspection we received information of concern about the safety and adequacy of the maintenance of the home. When we inspected on 7 December 2016 our findings supported the concerns that had been raised and we considered that people in receipt of care at Culworth House Care Home with Nursing were being exposed to unnecessary risks. The condition of the premises clearly evidenced that the home had not been adequately maintained and that repair work had not been carried out in a timely manner.

The only lift in the property had been condemned and prohibited from use since the 28 November 2016. There were no other lifts or stair lifts available to support people with mobility problems to move about the home. The provider had received a quote to replace the lift however stated that the price was significantly higher than expected and they were in the process of arranging another quote. There did not appear to be any urgency to resolve this matter quickly despite the provider being aware that estimations to have the lift repaired or replaced could take a further 14 weeks from the point of authorisation.

We saw that two people were able to access the downstairs areas independently and had chosen to do so. Most other people were being cared for in their bedrooms or small makeshift lounges in empty bedrooms on the 1st and 2nd floor of the home. People we spoke with told us that they were unhappy that the lift had broken and they were unable to spend time downstairs in the communal areas or go outside. One person said to us, "It's very bad. I can't even get outside. It's worse than prison! I'm not sure what the plan is for Christmas. I think my [relative] is trying to sort something out with them but it's not very good." Other people we spoke with told us that everything was a bit slower since the lift broke and they were spending more time in bed than before. One person said, "Sometimes I do get up and sit in my chair [in my bedroom] but there's not much point if I'm just in my room. I don't mind too much but I used to go downstairs every day before." Staff explained that they were doing their best but they had to do a lot more walking around to get people their food, drink and medicines.

During our inspection we found that externally the building showed signs of disrepair that would impact on the fabric/efficiency of the building. We asked for the environmental risk assessments and maintenance programmes relating to the maintenance and upkeep of the building. The area manager told us that they were unaware of any assessment or planned programme of maintenance for the building and they were reliant on their own maintenance staff to address issues of concern. The maintenance staff informed us they were able to carry out work to the home up to the height of a ladder, however the home was significantly taller than what they were able to address.

During our inspection we saw that tiles on the roof of the home were dislodged or missing. One tile had become caught in the guttering which posed a significant risk to people if it were to fall. There were no systems in place to regularly assess the integrity of the building and at the time of the inspection no action had been taken to assess the damage caused by the missing tiles or to repair the roof. There were no risk assessments in place to ensure people's safety from the damaged roof.

A member of staff told us that when it rained water came in through the roof and affected the ceiling on the top floor of the main staircase. They told us that during periods of rain the casing around the emergency light filled with water and that the smoke detector malfunctioned each time it rained. They said that at these times the fire panel displayed 'fault in Zone 6', until the smoke detector dried out, then the fault no longer appeared on the panel. We were concerned that water penetrating the smoke detector may impact on its effectiveness. At the time of the inspection, there had been very little rain recently so the light fixing appeared dry. However, there were some signs of water damage to the ceiling and it was evident that there was fresh paint as repairs had been made. We also found that the emergency lights were working however they had not been tested for almost a month, as the testing was due the week of the inspection.

Following the inspection the provider identified a report that had been completed by a fire and security firm on 19 September 2016 as they had been called to the home as a fault was showing on the fire panel systems. This confirmed that the smoke detector was getting damp on a recurring basis due to rainfall and they had proposed to move the smoke detector. This had been planned to be moved on 7 December. There had been little recognition of the potential dangers of the leaking roof, and no immediate action had been taken to remedy this situation. There had been no risk assessment following the water damage however at the CQC's request an electrician had been arranged to visit the property to complete a full assessment of the safety of the damage that had been made.

The provider confirmed that following the inspection a builder had visited the home to assess the condition and safety of the roof. A quote had been requested but at the time of the inspection no work had been agreed by the provider. The buildings had several chimneys located on the roofs which showed signs of disrepair. No assessments of the chimneys had been completed to ensure that they were safe and did not pose a risk to others. The builder recommended that the chimneys be made safer by wrapping them in scaffolding and netting and the provider has confirmed that this work will now be carried out.

The guttering systems from the roof were inadequate. There was a mixture of new plastic guttering and old metal guttering and much of the guttering was in a state of disrepair. There were areas where the guttering did not join up, and there were significant gaps, and plants were growing in the guttering, preventing the free flow of water drainage away from the roof and walls. On the outside wall of the annex the evidence of water damage was apparent as the wall was wet and had green algae growing on the wall. A member of staff told us that the water had penetrated inside and affected the bathroom on the first floor. We looked at this and saw that the wall in the bathroom showed signs of water penetration. The maintenance person told us they had applied anti-mould solution to the wall and repainted the wall many times to try and keep on top of the damage.

The call bell systems were inadequate for people living on the top floor. During the inspection we found that five people had their bedrooms on the top floor of the home. We found that although each person had access to a call bell to alert staff if they needed assistance, this was not working correctly. If people pressed their call bell, staff within the top floor could not hear the alarm and would not be alerted to this and would only become aware if they studied the control panel. The alert could be seen and heard by staff downstairs and they were able to respond to people's calls for assistance however this delayed responsive care, and could lead to a potential situation of staff being within hands reach of people but not being aware that they needed support. We observed that staff were carrying out 15 minute observations to ensure that people were observed and received regular care.

The provider explained that in light of this and since the lift had been condemned, an additional member of staff had been employed to support people and increase the checks that were in place to ensure people were safe. Following the inspection the provider had made a decision to move everybody that lived on the

top floor into a bedroom on a different floor so they would be able to request assistance when necessary.

The provider did not have systems and processes in place to maintain the safety of the home, ensure its integrity or to complete regular and robust assessments of the premises. There were no long term environmental plans to address longstanding issues or to keep on top of the maintenance of large and costly repairs.

We talked to the provider about our inspection findings and the serious concerns we had identified. The provider made a decision following our inspection that they would close the home; citing that they did not have the finances available to take all the action required to make the home safe.

In order to ensure peoples safety during the closure process we required the provider to immediately take a range of actions to address our concerns and to ensure that people's safety was not at risk. The provider took the urgent action that we asked for and gave the Commission assurances that any further issues that put people's safety at risk would be given the utmost priority. We continued to monitor and review this situation.

This was a breach of Regulation 15 (1) (c) (e) and Regulation 17 (2) (b).

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 The premises and environment were not assessed for their safety regularly or robustly to maintain people's safety.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Inadequate systems were in place to assess, review and monitor the condition of the premises.