GCH (Halcyon Days) Ltd

Halcyon Days

Inspection report

The Old Rectory
Church Lane,
Graveley,
Hertfordshire,
SG4 7LU
Tel: 01438 362245
Website: www.goldcarehomes.com

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Ratings

Overall rating for this service	Inadequate
Is the service safe?	Inadequate
Is the service responsive?	Inadequate
Is the service well-led?	Requires improvement

Overall summary

We carried out an unannounced comprehensive inspection of this service on 25 and 26 June 2015. After that inspection we received concerns in relation to the standard of care, infection control and prevention and staffing levels. As a result we undertook a focused inspection on 04 November to look into those concerns and to check on improvements made following the last inspection. This report only covers our findings in relation to those topics. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for (location's name) on our website at www.cqc.org.uk .

Halcyon Days provides accommodation and personal care for up to 56 people. At the time of this inspection there were 42 people living at the service.

There was a manager in post who not yet registered with the Care Quality Commission although they had submitted an application to do so. 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 the time of this inspection the new manager had been in post for two weeks.

At the last inspection in June 2015 we found the service was not meeting the required standards in relation to

Summary of findings

infection control and prevention, staffing and person centred care. The provider sent us an action plan to show what they were going to do to make the necessary improvements to meet the required standards.

At this inspection we found that no significant improvements had been made to the service since our last inspection, and that the provider was putting people at significant risk of harm.

People were not protected from the risks associated with the transmission of health related infections. The home was not cleaned to a satisfactory standard and staff did not follow good practice in relation to infection prevention and control.

The provider had increased staffing levels since the last inspection. However, staff did not demonstrate the skills and competence needed to meet people's needs safely. The necessary recruitment and selection processes were in place and the provider had taken steps to ensure that staff were suitable to work with people who lived at the home.

Some incidents which should have been treated as safeguarding issues were not reported. Staff did not always recognise abuse in all its forms which meant people were at risk of neglect.

Each person had a support plan in place detailing their needs and preferences. However, staff did not have a good knowledge of people's needs and did not engage with people sufficiently to reduce the risk of social isolation. People were not supported to pursue their hobbies and interests.

There were systems in place to monitor the quality of the service. However, recent audits had not been easily located and had not been used to make improvements to the service. The systems in place did not identify some of the issues that we found during our inspection.

Risks to people were assessed although accidents and incidents were not effectively monitored or learned from.

During this inspection we found the service to be in breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see the enforcement action we have taken and the action we have told the provider to take at the back of the full version of the report.

Special measures

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'.

The purpose of special measures is to:

• Ensure that providers found to be providing inadequate care significantly improve.

• Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.

• Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

The service will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

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?

Inadequate 

The service was not safe.

The home was not clean and some staff did not follow good practice in relation to infection control

Although there were enough staff on duty, they did not all have the skills to provide people with safe care.

Some incidents that should have been treated as safeguarding incidents had not been reported as such. Since the last inspection, some allegations of neglect investigated by the local safeguarding authority were substantiated

Medicines were managed safely.

Is the service responsive?

Inadequate 

The service was not responsive.

People did not have their individual needs met.

People were not supported to pursue their hobbies and interests.

People did not know who to complain to within the service and therefore some people went to external bodies when they had concerns instead.

Is the service well-led?

Requires improvement 

The service was not always well led.

A registered manager was not in post. The new manager was in the process of registering with the Care Quality Commission

The new management team had identified improvements to the service that were necessary but these had not yet been put in place.

There was a quality monitoring system in place but this had not been used to make improvements and concerns identified at the inspection had not been identified.

Staff were positive about the new manager.

Halcyon Days

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.

This inspection took place on 04 November and was unannounced. The inspection team consisted of two inspectors, a specialist advisor with expertise in Infection prevention and control and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. They had experience of caring for an elderly person and a care home environment.

Before the inspection, we reviewed information we held about the service. This included information we had received from people who used the service or their relatives, the local authority and the provider, including action plans and notifications of incidents. A notification is information about important events which the provider is required to send us by law.

During our inspection we spoke with 13 people who used the service and nine relatives. We also spoke with the manager of the home, the deputy manager, two senior managers, 5 care staff, one laundry assistant, one cleaner and one kitchen staff. We reviewed the care records of 10 people that used the service, five staff records, and records relating to how the provider assessed and monitored the quality of the service provided.

After the inspection visit we attended a meeting with health and social care professionals who worked with the home and gained feedback from them about the quality of the care provided.

Inadequate

Is the service safe?

Our findings

At our last inspection in June 2015 we found that the provider had not taken appropriate steps to ensure people were protected from the risk health related infections. There was a malodour in some areas of the home and it was visibly unclean. We also found that staff were not deployed effectively in all areas of the home to ensure people's needs were met. The provider sent us an action plan to tell us what they were going to do to make improvements to the service.

At this inspection we found that the required improvements had not been made.

Some people and their relatives commented that the home was not clean. One person said, "The home is not clean and tidy. Sometimes it is better than others." A relative said, "Cleanliness has been a problem and still is. Even this morning I found a nightie and a pair of knickers on the bathroom floor which they had just not picked up."

We saw that the level of cleanliness in the home was not sufficient to protect people from the risk of infection. There was a malodour present in the home and we found that some chairs, carpets and surfaces in the communal areas were not clean. Equipment used to support service users was soiled. This included hoists, commodes, wheelchairs, walking frames, toilets, beds and mattresses. Food debris was evident on chairs in the communal dining area and in the tray racks in the kitchen. This showed the cleaning regime in these areas was inadequate.

Some bathrooms were used to store equipment, and when asked, the deputy manager told us that the bathrooms were not in use. However, there was no signage to indicate the bathrooms should not be used and there was evidence of use in each.

We identified that food was not being stored appropriately to ensure that the risk of infection was minimised. For example, the carpet in the pantry was heavily soiled and food was stacked on the floor amongst empty cardboard boxes. We found unwrapped food in a freezer, which was iced up and soiled with food debris. Other freezers were overstocked which may have compromised the temperature at which food was kept. No logs of freezer temperatures were presented when asked for. This showed that people were not protected from the risks associated with eating food that has not been appropriately stored. The service had received a one star rating for food hygiene on the last Environmental Health Officer's (EHO) inspection therefore we referred this to the EHO to follow up.

We observed that staff practice in relation to infection control was poor. On repeated occasions during the inspection staff were seen to fail to remove personal protective equipment (PPE) before leaving people's bathrooms or bedrooms after providing personal care. Laundry staff were observed to handle both clean and dirty washing without wearing aprons. Kitchen staff failed to wash their hands after assisting service users before returning to prepare food.

Systems to monitor the cleanliness and the efficiency of infection control practices in the home were in place, but had not detected the issues identified at this inspection. Some of these monitoring systems had not been used for over six months.

We checked how the service was monitoring incidents and accidents that occurred in the home. Records relating to incidents and accidents that occurred between August 2015 and October 2015 were not immediately available and had to be searched for. When they were found, we noted that two people had a number of falls during this period. When we asked the management team how they had monitored and analysed incident and accident reports, they confirmed this had not happened because they did not have access to the previous registered manager's system. Therefore trends or patterns of incidents had not been looked for and the risk of reoccurrence had not been reduced. This meant people were at risk of harm because the service did not learn from incidents and take action to reduce them from happening.

These issues were a continued breach of Regulation 12 of the Health and Social Care Act 2008 (regulated activities) regulations 2014.

People and their relatives had mixed views about how safe they were at the service. Although many people told us they felt safe and that staff behaved appropriately towards them, they then went on to describe their experiences of poor care, which, in some instances, amounted to neglect. One relative said, "[Family member] had bed sores, [their] bottom was raw. I said to the carer '[name] needs some cream.' At first they said, 'There's nothing wrong with that.' I

Inadequate

Is the service safe?

had to insist. It is healing up now." Another relative said, "[Family member] has fallen out of bed so many times and they do nothing about it." This demonstrated that the care people received did not always keep them safe from harm.

Staff told us that they had received training on safeguarding procedures and were able to explain these to us, as well as describe the types of abuse that people might suffer. However, we identified two occasions where staff had not recognised incidents which should have been treated as safeguarding issues but were not appropriately reported to the local authority or to CQC. We also found that a number of safeguarding investigations had been carried out by the local authority since our last inspection, and that allegations of organisational neglect had been substantiated on at least two occasions. This indicated that although staff were able to describe the theory of safeguarding people, their ability to recognise potential abuse in all its forms was not sufficient to protect people from harm.

This was a breach of Regulation 13 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Staffing levels had improved since our inspection in June 2015. However, the way in which staff were deployed and tasks were allocated by senior staff, meant that some staff were extremely busy, whilst others appeared to have less to do. We saw the staff who were busy struggled to meet people's needs at times, but this was not always noticed by other staff who might have been in a position to lend assistance. About the competence of staff, one relative said, "The carers are mixed, some good but some awful. Some are difficult to understand and some are young and just have no experience." We found many of the staff on duty lacked the skills, competence and experience to meet people's needs safely. Some staff did not know the needs of the people they cared for and did not make full use of opportunities to engage with people who were left isolated and unstimulated as a result. Their lack of ability to recognise safeguarding incidents and their failure to observe good practice in relation to infection control put people at significant risk of harm.

This was a continued breach of Regulation 18 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

We saw that the necessary recruitment and selection processes were in place. We looked at staff files and found that appropriate checks had been undertaken before staff began work at the home. These included written references, and satisfactory Disclosure and Barring Service clearance (DBS). Evidence of their identity had been obtained and checked, and there was a clear record of the employees previous work experience and skills.

Each person had individual assessments in place which identified any areas of risk, such as a risk of falling or developing pressure ulcers, and how these would be minimised. We saw that people were involved in making decisions about risks and about how they would like to be supported to stay safe and maintain their independence as much as possible. Each person had a personal emergency evacuation plan within their care records which explained how they should be assisted to evacuate the premises safely in the event of an emergency. We saw that there were processes in place to manage risk in connection with the operation of the home. These covered all areas of the home management, such as fire risk assessment, water temperatures and electrical appliance testing.

People's medicines were administered safely. People were assessed to establish if they were able to manage their own medicines and where this was not possible or where they did not wish to, then the staff administered them. The system used was robust and enabled a full audit of how medicines were being managed. Medicines were stored in line with current good practice. Staff training was kept up to date to ensure they understood and were competent to administer medicines to the people who required them. Staff sought consent from people before medicines were administered and ensured that people took their medicines correctly

Inadequate

Is the service responsive?

Our findings

At our last inspection in June 2015 we found that, although there were some planned activities in the home, they did not take account of people's individual interests. Many people felt that they did not have enough to do, and some people said they felt lonely. We found that staff did not engage well with people and missed opportunities for stimulating interaction.

At this inspection we found that insufficient improvements had been made and, although there were some instances of positive engagement and basic steps had been made to provide more activities, people's needs were still not met in relation to these issues. One person told us, "One of the carers said to me one day, 'It would be better if you get rid of your marbles then you wouldn't have to worry anymore'. I suppose she's right! I get very lonely here. I never go out of my room. If I go downstairs everyone's asleep; it's so boring." Another person said, "There is nothing going on here. No activities, it is so boring! There is nothing to do downstairs; they just sit there looking at each other." Over a period of half an hour, we observed eight people who were sitting in a communal area. Three of the people were asleep and five were watching television or sitting passively in the room. During the 30 minutes, staff assisted four other people to enter the room, and although they spoke with the person they were supporting, the opportunity to engage with others in the room was missed. Many people told us that staff did not talk to them very much apart from to meet their needs for a drink or personal care. One person said, "My main problem here is loneliness."

The manager told us they were aware that there were not enough activities and events on offer at the service and they were in the process of addressing this. We saw that they had provided some activity equipment for staff to use. During the inspection we saw that staff made attempts to use the equipment to provide stimulation for people. However, we noted that, during the activity provided, staff engaged more with each other than with the people who were joining in.

People told us their individual needs were not met. One person said, "I need my computer to keep in touch with family abroad. When I came here I was told I would have it but now they say I can go somewhere else for two hours and use the computer. That's no good to me. I wouldn't have come here if I had known." Another person said, "I'm vegetarian. They keep giving me omelette. I do like fish too but they never ask what I want to eat. I've given up. I can't be bothered to keep asking." A relative told us, "[Family member] needs thickener in [their] liquids to stop [family member] choking and I still come in sometimes and find ordinary liquid in [their] room." One of the rooms had a notice placed on the door by relatives, which stated, "When entering the room please make sure [name] can see you and then help [them] with [their] hearing loop." We observed two staff members enter the room at different times and neither did this.

A recent incident took place at the service resulting in injury to one person and, in order to manage the risk, the management team took action which had a significant impact on another person who lived at the service. Although they told us they were aware of, and were concerned about this person's welfare, the management team had not put sufficient support in place to meet their emotional needs. This resulted in them being at risk of mental ill health. Therefore, the way in which the service managed this situation did not support each person involved to have their individual needs met.

When asked, staff were unable to give us clear, up to date information about people's individual needs. For example, we asked a member of staff and their senior colleague about one person's needs in relation to preventing the development of pressure ulcers. When discussed with the manager, it became apparent that neither of them were aware of the change in this person's care needs. We asked another member of staff about the needs of a person who was sitting in the lounge area. They said they did not know anything about the person and had not read their care plan. This demonstrated that staff did not have sufficient knowledge of people's changing needs and therefore there was a risk that people could receive inappropriate or unsafe care that did not meet their individual needs.

These issues were a continued breach of Regulation 9 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

People and their relatives told us that, although they knew how to make a complaint, they were unsure who they should make it to since the registered manager had left. Some people also said they did not have confidence that complaints would be responded to. One relative said, "There's no point really. Nothing would get done." Another relative said, "Well, we go to the office but it doesn't do

Inadequate

Is the service responsive?

much good." The Commission received several complaints about the service since the last inspection. Health and Social Care professionals reported that they had also received concerns from people or their relatives. However, the management team told us that they had not received any complaints. We concluded from this that the service did not have an effective system for receiving and managing complaints because they had not made it clear who people should complain to.

This is a breach of Regulation 16 of the Health and Social Care Act (Regulated Activities) Regulations 2014

We saw that the new manager and senior manager had started updating care plans and as a result the plans for people who were living in one area of the home were more person-centred, including more information about people's preferences and about what was important to them. The manager confirmed that this was an ongoing process and that all care plans would be updated to the new system in time.

Requires improvement

Is the service well-led?

Our findings

A new manager was in post who was not yet registered with the Care Quality Commission (CQC). The previous registered manager left in August 2015 and until the new manager took up their position in October 2015, temporary management arrangements had been in place. This contributed to a period of instability in the service which led to the quality of care deteriorating and an increase in complaints about the service received by CQC and social care professionals involved with the service.

The culture of the service was not open and did not encourage people to share their views. People were unsure about the management arrangements for the service and many people commented on the frequent changes of manager that had taken place in the last three years. One person said, "I've no idea who the manager is, and I've been here six months." Another person said, "No I don't know the manager. There are so many changes." Many people told us that they did not share their views with the staff or management because they either did not know who to speak with, or they did not feel that anything would change as a result.

We found that, although there was a quality assurance system in place, the most recent records could not be found on the day of the inspection, and had not been used to make improvements to the service. Many internal audits and checks, such as those in relation to infection control, had not been completed regularly since our last inspection, and if shortfalls had been identified, they had not been addressed.

Staff morale was low, although some staff said it was improving now that the new manager was in post. Staff had not received consistent support and their competence and work performance had not been monitored. A lack of leadership and guidance to staff resulted in them not having a clear understanding of their role or of the values of the service.

These issues were a breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) regulations 2014

The new manager and a new senior manager for the provider demonstrated very clear insight into the improvements that were required within the service. However, as they had only been in post for approximately three weeks, it had not been possible to implement the necessary changes yet They communicated openly and with honesty about the current quality of the service and showed a commitment to taking swift action to address the issues identified at this inspection. They had started work on producing a comprehensive action plan which included clear lines of responsibility and time scales within which each piece of work would be done. They recognised the need for a change in culture within the service and we saw that they were working hard with staff to promote good practice by supporting them well and providing positive role models for them. They had arranged to have meetings with residents and family members to discuss the development of the service and demonstrated that they were keen to involve people in decisions about how the service would be improved. Staff were positive about the new manager. One member of staff said, "[Name of manager] is great. Very approachable". Another member of staff said, "It's better. Morale has improved. The new manager is excellent."

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care People's care was not always planned or delivered in a manner which was appropriate, met their needs, or reflected their preferences Regulation 9 (1) (a) and (b) and (c)

The enforcement action we took:
The service was placed in special measures
An Urgent Notice of Decision was served to prevent admissions to the service without written agreement from the Care Quality Commission.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Appropriate steps were not taken to prevent and control the risk of infection. Accidents and Incidents were not analysed and learnt from to prevent reoccurrence. Regulation 12 (1) (2) (a), (b), (c), (e) and (h)

The enforcement action we took:
The service was placed in special measures
An Urgent Notice of Decision was served to prevent admissions to the service without written agreement from the Care Quality Commission.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment Staff did not report safeguarding incidents appropriately, and did not recognise poor Care which amounted to neglect. Regulation 13 (1-3)

The enforcement action we took:
The service was placed in special measures
An Urgent Notice of Decision was served to prevent admissions to the service without written agreement from the Care Quality Commission.

This section is primarily information for the provider

Enforcement actions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints The provider did not receive or manage complaints appropriately. Regulation 16 (1 - 3)

The enforcement action we took:
The service was placed in special measures
An Urgent Notice of Decision was served to prevent admissions to the service without written agreement from the Care Quality Commission.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 HSCA 2008 (Regulated activities)Regulations 2014 Good Governance Staff were not supported to do their jobs well, risks to people were not managed effectively and systems to evaluate the quality of the service were not effective or used to make improvements. Regulation 17(1) and 17(2)(a), (b) & (f)

The enforcement action we took:
The service was placed in special measures
An Urgent Notice of Decision was served to prevent admissions to the service without written agreement from the Care Quality Commission.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing The provider did not ensure that staff were deployed in such a way as to ensure people's needs could be met. Staff did not have the skills or knowledge to meet people's needs safely. Regulation 18 (1), (2)(a)

The enforcement action we took:
The service was placed in special measures
An Urgent Notice of Decision was served to prevent admissions to the service without written agreement from the Care Quality Commission.