

# GCH (Alan Morkill House) Limited

# Alan Morkill House

## Inspection report

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## Ratings

Overall rating for this service	Requires Improvement ●
Is the service safe?	Requires Improvement ●
Is the service effective?	Requires Improvement ●

# Summary of findings

## Overall summary

We carried out an unannounced comprehensive inspection of this service on 5 April 2016. Breaches of legal requirements were found regarding safe care and treatment and staff training. After the comprehensive inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to the breaches. After that inspection we received concerns in relation to the heating not working and issues with pest control.

We undertook this focused inspection to check that they had followed their action plan, to confirm that they now met legal requirements and to look into these concerns. This report only covers our findings in relation to these areas. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Alan Morkill House on our website at [www.cqc.org.uk](http://www.cqc.org.uk).

There was a registered manager at 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.

We received information that the building was not safe due to mice infestation and that the heating was not always working correctly. We saw that the provider had taken measures to address these issues.

At our previous inspection we found that the provider was not carrying out satisfactory measures to ensure water safety and the safe functioning of the call system. We found that the provider was still not fully meeting these requirements. Although the provider was carrying out satisfactory measures to protect people from legionella, there was not sufficient checking of water temperatures to protect people from the risk of scalding. The provider was not always carrying out checks to ensure that the call bell system was working correctly.

At our previous inspection we found that staff were not receiving sufficient training. We found that the provider was still not fully meeting these requirements. Although many staff had received training in key areas there were still some staff who had not received this training, and some staff did not undertake refresher training in line with the provider's requirements. Some staff who had recently joined the service did not receive training in important areas such as safeguarding.

We found that the provider was still breaching regulations with regards to safe care and treatment and staff training. You can see what action we have told the provider to take at the back of the full version of this report.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

The service was not safe in all areas. We found that action had been taken to improve health and safety checks, however these were still not adequate to ensure that call bells were working correctly and that water temperatures were safe.

The provider had taken appropriate measures to deal with issues relating to heating and pest control.

We could not improve the rating for effective from Requires Improvement because to do so requires consistent good practice over time. We will check this during our next planned comprehensive inspection.

**Requires Improvement** ●

### Is the service effective?

We found that action had not been fully taken to improve the effectiveness of the service. Staff had had some training in key areas, but the provider was not meeting its own training requirements for mandatory training and refresher training.

We could not improve the rating for effective from Requires Improvement because to do so requires consistent good practice over time. We will check this during our next planned comprehensive inspection.

**Requires Improvement** ●

# Alan Morkill House

## **Detailed findings**

### Background to this inspection

We undertook an unannounced focused inspection of Alan Morkill House on 2 December 2016. This inspection was done to check that improvements to meet legal requirements planned by the provider after our inspection on 5 April 2016 had been made and to look at other concerns we received about the service. We inspected the service against two of the five questions we ask about services: Is the service safe and is the service effective? This is because the service was not meeting some legal requirements.

The inspection was undertaken by a single inspector. During our inspection we spoke with five people who use the service. We also spoke with the Registered Manager, a team leader, the administrator, a handyperson, four care workers and a pest control operative who was visiting the premises. We carried out observations of the building and looked at records relating to health and safety and staff training.

# Is the service safe?

## Our findings

We received information of concern that the building may not be safe as the heating was not working and that there were problems with mice. We saw that the provider had taken appropriate measures to address these issues. The provider had a contract with a professional pest control contractor who had visited the building to carry out an initial survey and taken measures such as putting down traps. On a later visit, the contractor had recorded that there was an improvement in the situation and that there was no fresh evidence of mice. On the day of our inspection, the contractor told us they had seen no further evidence of mice but were continuing to monitor this.

Records showed that the heating was not functioning in some areas of the building on two occasions in November, and that managers had called out heating engineers who had carried out repairs and made recommendations. The provider told us that they were in the process of implementing these recommendations, which included carrying out a power flush of the system. All areas of the building were warm on the day of our visit, and people we spoke with told us that they were warm enough. A staff member told us, "The manager has dealt with the issues, I haven't seen any more signs of it."

At our last inspection in April 2016 we found that checks to ensure the building was safe were not adequate. This was because the provider was not carrying out checks to ensure the call bell system was working, which had resulted in the system not working for periods of time without staff being aware. We also found that the provider was not carrying out weekly flushes on vacant water outlets, despite this being a recommendation in the risk assessment for legionella.

At this inspection we found that improvements had been made, however these were not always being followed in accordance with the provider's action plan.

The provider told us that the call bell system would be checked by staff on every shift. However, we found that in practice this was being carried out on a daily basis, and on three occasions in October these checks had not been carried out. On one day, staff had checked the system at 8:50am and found that it was not working; the last check of the system had been the day before at 9am. We checked the logs of the call system for six people using the service who used the system on at least a daily basis and found that there were no calls recorded for the period following this check, which meant that the system was not working properly during this time. We reviewed people's care logs and incident records for this period and did not find that significant incidents were missed by staff, however people may have been at risk if they had needed to call staff for help during this time.

Flushing of vacant outlets was being carried out weekly by staff in line with the provider's legionella risk assessment, these logs contained detailed instructions for staff on how to carry out these measures correctly.

Records of water safety also showed that the provider carried out monthly checks of hot water temperatures, including for showers in people's rooms. However, some showers showed high temperatures

which may be unsafe, and action had been taken to address some, but not all of these. The provider told us that they carried out checks of water temperatures prior to carrying out personal care, however this was not the case. This meant that people may be at risk of scalding from high temperatures.

These issues meant that despite some improvements, the provider was still in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

We were unable to improve the rating for this question from requires improvement to good because we found that concerns had not been fully addressed and sustained over a period of time. A further inspection will be planned to check if improvements have been made.

## Is the service effective?

### Our findings

At our last inspection in May 2016 we found that the provider had not provided adequate training for all staff. We found that a third of staff had not undertaken training in dementia awareness, despite the service providing care to 11 people with a diagnosis of dementia. We found that significant numbers of staff had not had training in fire safety, safeguarding adults, infection control, Control of Substances Hazardous to Health (COSHH) and Health and Safety.

At this inspection, we saw that the provider had made progress towards improving staff training, but was not fully meeting this requirement.

Since our last inspection, the provider had arranged training for staff in these areas. We found 16 staff had received training on dementia awareness, 14 staff had been trained in safeguarding adults, 13 in infection control, 21 in COSHH and 18 in health and safety. However, there were still gaps in training. For example, five staff had not had safeguarding adults training, eight had not had infection control and seven had not had training in COSHH, despite the provider considering these to be mandatory. Seven staff had not received training in dementia awareness, although the provider did not consider this a mandatory course for staff.

We also found that the provider was not meeting its own requirements for staff to receive refresher training in these areas. For example, staff were required to have yearly training in safeguarding adults, but eight staff were overdue for this. Nine staff were overdue for infection control training which was required every two years, this included six staff who were more than six months overdue. We found 12 staff who were overdue for two yearly health and safety training and that 16 staff did not have either a three yearly first aid qualification or up to date basic first aid, although it was a requirement for all staff to have received this every two years. The provider told us they had already arranged training for safeguarding adults and would be arranging the outstanding training as a matter of urgency.

We found that five staff who had started in the past year had not had training in certain key areas. All five of these staff had not received food hygiene training, four had not received infection control training and three had not received safeguarding adults, fire safety awareness, first aid or COSHH training. The provider told us these staff were in the process of completing a recognised care qualification.

This meant that, despite improvements the provider was still in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We were unable to improve the rating for this question from requires improvement to good because we found that concerns had not been fully addressed and sustained over a period of time. A further inspection will be planned to check if improvements have been made.

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 12 HSCA RA Regulations 2014 Safe care and treatment  Care was not being carried out in a way which ensured the safety of people who used the service. Regulation 12(1)(2)(e)(h)
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing  Staff did not receive appropriate training to enable them to carry out the duties they were employed to perform. Regulation 18(2)(a)