Commission for Social Care Inspection

Making Social Care Better for People

Inspecting for better lives

Random inspection report

Care homes for adults (18-65 years)

Name:	Goldcrest House
Address:	194 Boothferry Road Goole East Yorkshire DN14 6AJ

The quality rating for this care home is:	two star good service
The rating was made on:	

A quality rating is our assessment of how well a care home, agency or scheme is meeting the needs of the people who use it. We give a quality rating following a full assessment of the service. We call this a 'key' inspection.

This is a report of a **random inspection** of this care home. A random inspection is a short, focussed inspection. Details of how to get other inspection reports for this care home, including the last key inspection report, can be found on the last page of this report.

Lead inspector:	**Date:**							
Diane Wilkinson	0	6	0	2	2	0	0	9

Information about the care home

Name of care home:	Goldcrest House
Address:	194 Boothferry Road Goole East Yorkshire DN14 6AJ
Telephone number:	01405763329
Fax number:	
Email address:	goldcresthouse@onetel.net
Provider web address:	

Name of registered provider(s):	Genhawk Limited
Type of registration:	care home
Number of places registered:	10

Conditions of registration:		
Category(ies) :	Number of places (if applicable):	
	Under 65	Over 65
learning disability	10	0
sensory impairment	10	0

Conditions of registration:								
Date of last inspection								

Brief description of the care home

Goldcrest House is a care home that provides care and accommodation for 10 younger adults with a learning disability; it is owned by Genhawk Limited. The home endeavours to empower service users in order to maximise their social and independent living skills, and they are in the process of becoming accredited with the National Autistic Society.

Accommodation is provided in single rooms that have been furnished to a good standard. Service users have access to a range of shared space, including a lounge, a dining room and a small well-maintained garden and patio area to the rear of the building, which is equipped with garden furniture.

What we found:

We checked the care records for one resident living at the home. These did not include a care needs assessment but we were told that these were stored in the main office so that they could be held securely; the assessment for the resident concerned was later shown to the inspector. We observed that information is obtained from the local authority and from the person's previous place of residence (where appropriate) and that all of this information is used to develop an individual plan of care for each resident. The registered manager should consider storing a copy of the care needs assessment with care plan information so that staff have access to full details of the person concerned.

Individual care plans are a good record of the person's personal history and previous lifestyle. They include up to date information about a person's capabilities and any assistance needed from staff or other health care professionals. Behaviour management plans and risk assessments are also included, as well as very thorough monthly summaries that record how people have spent the previous month, including activities undertaken, any illnesses or concerns, any special events and any family contact. Monthly key worker meetings are held and recorded - an overview of general health, diet, living skills and personal hygiene for each resident is discussed.

There is evidence in care plans that residents are supported and encouraged to make decisions about their day to day lives, and that responsible risk taking is considered and supported. There is a document in place that records the required intervention and any restrictions on choice or freedom. For example, some residents are given the freedom to come and go from the home but this is on condition that they tell staff when they are leaving and when they return.

On the day of this site visit most residents were out taking part in a variety of activities. Some were at college and others were attending a social group where they were rehearsing for a production of The Sound of Music. One resident was out shopping on their own, and other residents had been out for a walk with staff. Residents told us on the day of the site visit about paid employment and staff told us about a variety of facilities that are available for residents locally. In addition to this, the company have purchased a caravan at the coast and residents go for the weekend, in small groups, on a regular basis. Residents told us that they enjoyed visiting the caravan and taking part in activities in the surrounding area. Staff believe that this has increased the confidence of some residents who are getting used to visiting and socialising in another area. Bedrooms included a small display cabinet that was securely attached to the wall where information about daily activities for each individual was displayed; this is good practice.

Care plans record any contact with family and friends and there is evidence that this is supported by staff. Residents are supported to make telephone calls and write letters to family members, and discussions with residents on the day of the site visit confirmed this. Staff were seen to interact well with residents and in one instance, this was seen to be a sensitive and supportive interaction.

There is a four week menu in operation but we noted that this is not always adhered

to. The menu is varied and we saw evidence that residents discuss the menu at their meetings and are able to make suggestions about preferred foods, and that these are added to the menu. However, we observed that little progress had been made in ensuring that dietary requirements are met in a healthy way. We discussed this with the manager and suggested that more vegetables and salad could be introduced to the menu.

Care plans evidence that health and social care professionals are contacted on behalf of residents when assistance is needed or advice is required. We examined the medication records for two residents and noted that medication administration records include a photograph of the resident concerned and clearly identify the time that a person should receive prescribed medication. The medication administration record for one person evidenced that two written entries had been made for the same medication bought as a 'homely' remedy. In addition to this, a further 'homely' remedy had been purchased and used. This error could have resulted in a resident having an overdose of this drug. The registered manager told us that this would be rectified immediately. We noted that there were some gaps in recording.

We asked about an annual health check for the person being case tracked and were told that these do not take place routinely, but as and when needed, for example, at the time of a medication review or when a referral for additional services is made.

We examined the complaints log and observed that a record is made of the complaint made and any action taken. The deputy manager told us that safeguarding training is booked for staff on the 24th February; this is initial training for new staff and an update for established staff. We were told that staff at senior carer level and above attend the manager's safeguarding training course.

We checked the bedrooms of two residents and communal areas of the home. The dining room has recently been refurbished and is a pleasant area for residents to take their meals and socialise with others. One of the bedrooms had a painted concrete floor and the resident concerned said that they would like a carpet to be fitted. It was acknowledged that this person had some difficulty in caring for their furniture and fittings and that action was being taken to improve that situation, but consideration should be given to a carpet being provided. The other bedroom seen had been personalised to suit the needs of the resident concerned and included equipment to promote sensory activities.

We examined the recruitment records for a newly appointed member of staff. These included an application form, two written references and a Protection of Vulnerable Adults (POVA) first check. However, records evidenced that the person had commenced work two days prior to the POVA first check being received. This staff member had commenced Induction training and we noted that not much progress had been made towards completion. Individual training records are held but there is no training and development plan that records the training achievements and needs of the whole staff group. A training and development plan also assists with identifying when refresher training is needed. We asked if staff had completed training on infection control and were told that this has not yet been achieved.

We checked the fire safety records held at the home. There is a fire risk assessment in place and an annual fire test and fire extinguisher test took place in January 2009. Fire

drills take place on a monthly basis but the in house weekly fire tests had not been done since September 2008. This puts residents and staff at risk of harm. Due to the absence of a training and development plan it was not possible to check when staff last had fire safety training. A test to detect the presence of Legionella in the water supply had been carried out following the last key inspection and the deputy manager told us that a further test had taken place in January 2009.

What the care home does well:

Individual care plans are a thorough record of a person's capabilities and assistance needed that are reviewed and updated on a monthly basis.

Residents are encouraged to make decisions about their day to day lives and responsible risk taking is considered and supported.

Bedrooms included a display cabinet where information about the individuals activities for that day are displayed.

The dining room has been refurbished and provides pleasant surroundings for residents to take their meals and socialise with others.

What they could do better:

The weekly menu should be adhered to so that the foods provided for residents can be monitored and healthy eating promoted.

More care must be taken with the completion of medication administration records to ensure accuracy and to protect residents from the risk of harm.

There are arrangements in place for weekly fire tests to take place but these had not been adhered to. This does not protect residents and staff from the risk of harm.

Staff should not commence work until all safety checks are complete to ensure that only people safe to work with vulnerable people are employed.

If you want to know what action the person responsible for this care home is taking following this report, you can contact them using the details set out on page 2.

Are there any outstanding requirements from the last inspection?				
	Yes	☐	No	☑

Outstanding statutory requirements

These requirements were set at the last inspection. They may not have been looked at during this inspection, as a random inspection is short and focussed. The registered person must take the necessary action to comply with these requirements within the timescales set.

No.	Standard	Regulation	Requirement	Timescale for action

Requirements and recommendations from this inspection

Immediate requirements:

These are immediate requirements that were set on the day we visited this care home. The registered person had to meet these within 48 hours.

No.	Standard	Regulation	Requirement	Timescale for action

Statutory requirements

These requirements set out what the registered person must do to meet the Care Standards Act 2000, Care Homes Regulations 2001 and the National Minimum Standards. The registered person(s) must do this within the timescales we have set.

No.	Standard	Regulation	Requirement	Timescale for action
1	20	13	More care must be taken to ensure accurate recording on medication administration records. This is needed to protect residents from the risk of harm i.e. residents could receive more than the recommended dosage of 'homely' remedies.	20/02/2009
2	34	19	Staff must not commence work until all safety checks have been requested and responses received. This is to ensure that only people who are safe to work with vulnerable people are employed.	20/02/2009
3	42	13	Weekly fire tests must take place consistently. This is needed to protect residents and staff as far as is possible from the risk of fire.	20/02/2009

Recommendations

These recommendations are taken from the best practice described in the National

Minimum Standards and the registered person(s) should consider them as a way of improving their service.

No.	Refer to Standard	Good Practice Recommendations
1	17	The four weekly menu should be adhered to ensure that foods provision can be monitored. Considersation should be given to how the menu could be improved to promote healthy eating.
2	19	Residents should be offered an annual health check.
3	35	There should be a training and development plan in place that records the training achievements and needs for the full staff group; this would also assist in identifying when refresher training is needed.
4	42	Staff should receive training on infection control to ensure that they are aware of safe practices to maintain hygiene standards and reduce the risk of cross infection.

Reader Information

Document Purpose:	Inspection Report
Author:	CSCI
Audience:	General Public
Further copies from:	0870 240 7535 (telephone order line)

Our duty to regulate social care services is set out in the Care Standards Act 2000. Copies of the National Minimum Standards –Care Homes for Adults (18-65 years) can be found at www.dh.gov.uk or got from The Stationery Office (TSO) PO Box 29, St Crispins, Duke Street, Norwich, NR3 1GN. Tel: 0870 600 5522. Online ordering from the Stationery Office is also available: www.tso.co.uk/bookshop

Helpline:

Telephone: 0845 015 0120 or 0191 233 3323

Textphone: 0845 015 2255 or 0191 233 3588

Email: enquiries@csci.gsi.gov.uk

Web: www.csci.org.uk

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