Inspection Report

We are the regulator: *Our job is to check whether hospitals, care homes and care services are meeting essential standards.*

The Hall Nursing Home

100 Old Station Road, Bromsgrove, B60 2AS

Tel: 01527831375

Date of Inspection: 01 November 2013

Date of Publication: March 2014

We inspected the following standards in response to concerns that standards weren't being met. This is what we found:

Safety and suitability of premises	✖ Enforcement action taken

Details about this location

Registered Provider	Southern CC Limited
Registered Manager	Mrs. Stephanie Jayne Webley
Overview of the service	The Hall Nursing Home is registered to provide accommodation for up to 43 older people who need nursing or personal care.
Type of service	Care home service with nursing
Regulated activities	Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury

Contents

When you read this report, you may find it useful to read the sections towards the back called 'About CQC inspections' and 'How we define our judgements'.

Summary of this inspection

Why we carried out this inspection

We carried out this inspection in response to concerns that one or more of the essential standards of quality and safety were not being met.

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 1 November 2013, observed how people were being cared for and talked with staff. We reviewed information given to us by the provider, reviewed information sent to us by commissioners of services, reviewed information sent to us by other regulators or the Department of Health and talked with commissioners of services. We talked with other regulators or the Department of Health.

What people told us and what we found

We carried out this inspection due to the concerns that we had received from the local authority and other regulators.

At this inspection we did not speak with people who lived at the home as we wanted to be sensitive to their needs at this difficult time. However, we spoke with the manager, operations manager and some staff who worked at the home. The management team and the staff that we spoke with told us that people who lived at the home received care and support from staff that met their needs.

We spent time with the new staff member who had delegated responsibility for the maintenance of the home environment. They showed us the repair work that needed to be done. We saw that some of the work had been outstanding for a period of time. However we could not find a responsive and planned approach to get the repair work done that made sure The Hall Nursing Home was a suitable and safe place for people to live.

We also looked at the quality assurance arrangements the provider has in place to check the premises. We found that these did not effectively identify the shortfalls in all the maintenance work required to ensure that any work and repairs were dealt with in a responsive and timely way. This meant that the homes environment was not always consistently developed, reviewed and improved as needed to meet the needs and safety of the people who lived at the home.

In this report the name of a registered manager appears who was not in post and not managing the regulatory activities at this location at the time of the inspection. Their name appears because they were still the Registered Manager on our register at the time.

You can see our judgements on the front page of this report.

What we have told the provider to do

We have taken enforcement action against The Hall Nursing Home to protect the health, safety and welfare of people using this service.

Where providers are not meeting essential standards, we have a range of enforcement powers we can use to protect the health, safety and welfare of people who use this service (and others, where appropriate). When we propose to take enforcement action, our decision is open to challenge by the provider through a variety of internal and external appeal processes. We will publish a further report on any action we take.

More information about the provider

Please see our website www.cqc.org.uk for more information, including our most recent judgements against the essential standards. You can contact us using the telephone number on the back of the report if you have additional questions.

There is a glossary at the back of this report which has definitions for words and phrases we use in the report.

Our judgements for each standard inspected

Safety and suitability of premises ✖ Enforcement action taken

People should be cared for in safe and accessible surroundings that support their health and welfare

Our judgement

The provider was not meeting this standard.

People who lived at the home, staff and visitors were not protected against the risks of unsafe or unsuitable premises.

We have judged that this has a major impact on people who use the service and have taken enforcement action against this provider. Please see the 'Enforcement action' section within this report.

Reasons for our judgement

At this inspection we talked with the manager and the operational manager about the general upkeep of the building as we had received concerns about the safety and suitability of these premises. We also looked at some quality audits and service histories that had been completed for the premises and equipment.

We walked around the majority of the home environment and looked at some of the quality audits that had been completed.

During this inspection we found examples that the facilities were not always suitable to meet the needs of the people who lived at the home and ensured their safety.

We saw that a ground floor bathroom had an electric plug socket that was not covered and was situated directly next to the shower. Although the shower was not in operation at the time of our inspection it had previously been used. Therefore the provider had not taken the necessary action to make the bathroom a safe place for the people who lived at the home. We found that the maintenance person had recently recognised the risk that the electric plug socket posed. However the provider had not taken the required action to remove the hazard of the electric plug socket in the bathroom. This posed a serious risk to the safety of the people who lived at the home and the staff who supported people.

During this inspection we went into a number of rooms on the first floor that was vacant. We found that the supply of hot water taps in the sinks was barely luke warm to the touch. When we spoke with one member of staff they told us that on the day of our inspection the hot water that they needed during the day was collected from one person's room. This

meant that staff carried hot water from one room to other rooms so that they could provide care to people who lived on the first floor of the home. These practices placed people who lived at the home and staff at risk. This also meant that the person whose room staff collected the hot water from would be disturbed throughout the day as staff used their hot water tap. Therefore these arrangements did not protect this person's right to privacy.

We discussed this with the manager and the operations manager. They told us that they had not been informed of the lack of hot water supply in the rooms situated on the first floor of the home. The manager told us that they would contact a plumber.

We looked at the records that showed the water temperatures had not always been checked on a monthly basis. For example we could not find the checks for the month of September 2013. We saw that staff had written down when the water temperatures required some adjustments to meet the correct temperatures to protect people from the risk of scalding.

We received a copy of the prohibition notice that the provider had received from the Health and Safety Executive in October 2013. This showed that the action was required by the provider to ensure that people who lived at the home were not placed at risk from Legionella. The Health and Safety Executive will follow this up.

The provider sent us the certificates that showed the on-going actions that had been taken so far. For example, the water was being tested. We also received information that showed the on-going work to treat the water supply in the home so that the health and wellbeing of people who lived at the home was not placed at risk.

During our inspection we saw that people were not able have a bath or shower due to the on-going work and tests on the water systems. However, the staff that we spoke with told us that they helped people to have strip washes. This meant that people continued to have their personal care needs met and were not placed at risk by staff that used the showers.

We saw that an extractor fan from one room went into another person's room. The staff that we spoke with told us that the fan was not used. However, there was a hole in the person's wall and it did not show that the person's room was well maintained and there was a risk that dust could collect in this. There was no scheduled action in place to remedy this situation at the time of this inspection.

We found that the nurse call bells did not work as they should to ensure that staff were always alerted when people who lived at the home required assistance. When we discussed this with the management team they told us that staff checked on people regularly who remained in their bedrooms. This meant that the risks to people whilst the call bells did not operate as they should had been reduced. The manager told us that the nurse call bell system had been looked at by a contractor so that the required work could be done to ensure that the system worked properly. However we could not find any clear documentation that confirmed that the work had been scheduled so that if the contractor did not respond this work would not be missed.

We saw that that people had a choice of lounges to sit and do activities in. However, the manager told us that some of the chairs were not appropriate for people as they were too low and difficult for people to sit in and get up from. This meant that that the chairs needed to be replaced to ensure that they met people's physical needs and people could sit with comfort. We could not find any documentation to confirm that the chairs were scheduled to

be replaced.

We could not evidence that the provider's in-house maintenance checks and schedules of the work required had been always completed regularly. We discussed this with the manager and the operations manager. The management team acknowledged that these had lapsed because maintenance staff had left. At our inspection we spoke with the new maintenance person.

We found that the new maintenance person had now walked around the premises. They had identified a significant amount of maintenance work that was required to be done which included repairs to the home environment. For example, plug sockets to be made safe and lights and extractor fans that did not work. This showed that there had been a lack of consistency of in-house regular maintenance checks as these should have identified the work required. This meant that risks and early indicators of where action may be needed to maintain the quality and safety of the premises for the people that lived at the home had been missed with no action taken.

After our inspection the provider sent to us evidence that six monthly and yearly maintenance service checks had been completed. These included gas safety, lift and hoists. We also looked at the health and safety audit that had been completed in August 2013. This showed that the provider had some arrangements in place to ensure maintenance checks were completed by service contractors.

However, we could not find consistency in the in-house checks of maintenance work that would highlight any problems before six monthly and yearly services. This meant the provider did not effective arrangements in place to ensure that the premises remained suitable to meet the needs of the people who lived there and ensured their safety.

Before our inspection we had received a copy of the fire audit that had been completed by the Hereford and Worcester Fire and Rescue Service. We saw that a number of fire deficiencies had been identified and the provider was required to take action by 29 January 2014 to ensure that they complied with fire standards and people who lived at the home were safe. The Hereford and Worcester Fire and Rescue Service will follow this up.

We looked at the fire risk assessment and checked one of the improvements that were required. We saw that the improvement action to remove a smoke alarm to a higher position had been done. We also found that all the people who lived at the home had a personal evacuation plan in place so that staff had this information to meet the needs of people in the event of a fire.

The garden area of the home had been overgrown and required some work. We found that some tidying of the garden had taken place but there was a pergola structure in the garden that was unsafe. The wood had rotted and the concrete was damaged. This meant the whole garden area was not safe for people who lived at the home to use as an outdoor space for the benefit of getting some fresh air.

This section is primarily information for the provider

✖ Enforcement action we have taken to protect the health, safety and welfare of people using this service

Enforcement actions we have taken

The table below shows enforcement action we have taken because the provider was not meeting the essential standards of quality and safety (or parts of the standards) as shown below.

Imposition of condition of registration This action has been taken in relation to:	
Regulated activities	Regulation or section of the Act
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	**Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010** **Safety and suitability of premises** **How the regulation was not being met:** The provider must ensure that people who use the service are protected from the risks associated with unsafe or unsuitable premises and must ensure that the premises are appropriately maintained. Regulation 15(1)(a)(c)

For more information about the enforcement action we can take, please see our *Enforcement policy* on our website.

About CQC inspections

We are the regulator of health and social care in England.

All providers of regulated health and social care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as "government standards".

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of other services less often. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service's records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.

How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

✓ **Met this standard**	This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.
✖ **Action needed**	This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.
✖ **Enforcement action taken**	If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.

How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. Only where there is non compliance with one or more of Regulations 9-24 of the Regulated Activity Regulations, will our report include a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation). This could be a minor, moderate or major impact.

Minor impact - people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

Moderate impact - people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

Major impact - people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.

Glossary of terms we use in this report

Essential standard

The essential standards of quality and safety are described in our *Guidance about compliance: Essential standards of quality and safety*. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the *Guidance about compliance*. The 16 essential standards are:

Respecting and involving people who use services - Outcome 1 (Regulation 17)
Consent to care and treatment - Outcome 2 (Regulation 18)
Care and welfare of people who use services - Outcome 4 (Regulation 9)
Meeting Nutritional Needs - Outcome 5 (Regulation 14)
Cooperating with other providers - Outcome 6 (Regulation 24)
Safeguarding people who use services from abuse - Outcome 7 (Regulation 11)
Cleanliness and infection control - Outcome 8 (Regulation 12)
Management of medicines - Outcome 9 (Regulation 13)
Safety and suitability of premises - Outcome 10 (Regulation 15)
Safety, availability and suitability of equipment - Outcome 11 (Regulation 16)
Requirements relating to workers - Outcome 12 (Regulation 21)
Staffing - Outcome 13 (Regulation 22)
Supporting Staff - Outcome 14 (Regulation 23)
Assessing and monitoring the quality of service provision - Outcome 16 (Regulation 10)
Complaints - Outcome 17 (Regulation 19)
Records - Outcome 21 (Regulation 20)

Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.

Glossary of terms we use in this report (continued)

(Registered) Provider

There are several legal terms relating to the providers of services. These include registered person, service provider and registered manager. The term 'provider' means anyone with a legal responsibility for ensuring that the requirements of the law are carried out. On our website we often refer to providers as a 'service'.

Regulations

We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

Responsive inspection

This is carried out at any time in relation to identified concerns.

Routine inspection

This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.

Themed inspection

This is targeted to look at specific standards, sectors or types of care.

Contact us

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