Inspection Report

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

Holy Name Care Home

Hall Road, Hull, HU6 8AT

Tel: 01482803388

Date of Inspection: 11 October 2013

Date of Publication: February 2014

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

Care and welfare of people who use services	✖ Action needed
Safeguarding people who use services from abuse	✖ Action needed
Safety and suitability of premises	✖ Action needed
Notification of other incidents	✖ Action needed
Notifications – notice of absence	✖ Action needed

Details about this location

Registered Provider	Molescroft Nursing Home (Holdings) Limited
Registered Manager	Mrs. Samantha Jayne Crick
Overview of the service	Holy Name Care Home is a purpose built home encompassing a church site, situated in a residential area of North Hull. The home has a number of open plan areas, two conservatories and gardens for people to use. The home was opened in 2012 to provide long term and respite stays for older people who need residential or nursing care. The home is registered for 64 older people, some of whom may have dementia. The home is situated on main public bus routes into Hull City Centre.
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 11 October 2013, observed how people were being cared for and checked how people were cared for at each stage of their treatment and care. We talked with people who use the service, talked with carers and / or family members and talked with staff.

What people told us and what we found

We visited the service following concerns received about the effective management of some maintenance systems. We had also been made aware of some concerns about people's care and welfare.

People we spoke with told us they received the care and support they needed and they were very happy with how staff delivered their care. One person told us, "Staff are very kind and are always there to help me." A visitor said, "We have been very satisfied with the care mum gets, she is very settled." However we found not all people's needs were assessed and their care and treatment was not always planned effectively.

A visiting health professional told us that staff were now making appropriate referrals for routine and emergency support with health care issues.

People told us they felt safe and comments included, "Happy here" and "Staff are polite and respectful." However people were not fully protected from abuse as some staff had limited understanding about the types of incidents they should report and which external agencies they could report concerns to.

People spoken with told us they liked their home. They said it was warm and very comfortable. The premises were clean. The quality of décor and furnishings was of high standard. However we found some of the maintenance systems did not fully protect people from the risks associated with unsafe premises.

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

What we have told the provider to do

We have asked the provider to send us a report by 17 December 2013, setting out the action they will take to meet the standards. We will check to make sure that this action is

taken.

Where we have identified a breach of a regulation during inspection which is more serious, we will make sure action is taken. We will report on this when it is complete.

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

Care and welfare of people who use services ✖ Action needed

People should get safe and appropriate care that meets their needs and supports their rights

Our judgement

The provider was not meeting this standard.

Care and treatment was not always planned and delivered in a way that was intended to ensure people's safety and welfare.

We have judged that this has a moderate impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

Prior to this visit we had attended meetings with the local placing authority, the local authority safeguarding team and the provider to discuss some concerns about standards of care and standards of the care records. The provider was working to an agreed action plan developed with the placing authority to address the shortfalls in these areas.

The recently appointed nurse manager told us they had rewritten 80% of the care records. During this visit, we looked at five care files; three of these had been rewritten.

The standard of recording in the recently reviewed files was found to be of a good standard. These files demonstrated that people's needs had been re-assessed and new care plans had been developed to support all identified needs. We found these care plans to be detailed, comprehensive and contained a high level of personalised information to direct staff on how to provide the care the person needed and in the way they preferred.

However we found shortfalls in the two care files which had not been rewritten. One person's records showed they had been admitted in July 2013 following a fall, when they had sustained a fracture. The placement at the home had been arranged through the intermediate care team. Checks on this person's care file showed the majority of records had been completed by the intermediate care team. This team funded people who needed short term treatment and support which enabled them to return home if and when they were able to manage this. The nurse manager confirmed the person was now residing permanently at the service and the intermediate care team were no longer providing support for this person.

We found that the staff at the service had not completed an assessment of the person's needs which included the risks associated with this person's care. Nor had the staff at the

service completed any care plans to describe the support the person needed. We found the staff at the service maintained daily records to support the care they delivered. These showed they provided the person with personal care support; monitored the person's mobility, skin damage and also monitored the person's dietary intake. We found the risk assessment for mobility had not been reviewed, nor had the person had a risk assessment for falls completed since admission to the home even though this was the primary reason for the admission.

Checks on another care file showed some inconsistencies with aspects of risk management and recording of incidents. The care plan included information about specific areas where the person was more at risk and explained what action staff needed to take to protect them. However, documents had not always been completed consistently. Daily records showed the person had sustained a skin injury on the 14 September 2013 whist transferring to their wheelchair from the bed. This had been checked by the GP and a wound care plan developed. An incident form had also been completed and this incident had been recorded on the manager's overview incident record.

However there were fewer records to support action taken when the person sustained further skin tears on the 21 September 2013. These injuries were detailed in the professional visitor records; they identified that the emergency care practitioner (ECP) had been contacted, visited and provided treatment. An accident form had been completed but this injury had not been recorded in the manager's overview incident record. Staff had not recorded any detail of this injury in the daily records nor had the injuries been detailed on a wound care plan. There was no record of any further treatment or care provided to the person's wounds, either by the staff at the home or by the community health team. When we spoke with the nurse on duty they confirmed the person's wounds had now healed.

When we visited this person we found their bed rails did not have protectors fitted to reduce the risk of injury from the rails. Discussions with the qualified nurse on duty identified that the person chose not to have the protectors in place. However we found the person's care records and risk assessments had not been updated to reflect this, nor had the use of alternative equipment been considered. This could lead to the person not being supported correctly.

We spoke with one health care professional during our inspection. They considered that communication between the home staff and the community teams had improved in recent weeks. They also said how people who used the service were now referred to the ECP when necessary.

We spoke with four people who used the service and two visitors who all said they were happy with the care provided and complimented the staff for the way they cared for people. One person told us, "Everything about this home is good: the staff are lovely, my room is very comfortable and I'm happy with the care." Another person told us, "Staff are very kind and are always there to help me." A visitor said, "We have been very satisfied with the care mum gets, she is very settled."

During our observations we noted positive interaction between the staff and people who used the service. We observed when people needed support staff were attentive and provided this in a sensitive and kind way. When we spoke with staff they demonstrated a good understanding of the action they should take if people required any emergency care support. They showed a good understanding of the needs of the people they cared for.

Safeguarding people who use services from abuse ✖ Action needed

People should be protected from abuse and staff should respect their human rights

Our judgement

The provider was not meeting this standard.

People who used the service were not protected from the risk of abuse, because the provider had not taken reasonable steps to identify the possibility of abuse and prevent abuse from happening.

We have judged that this has a minor impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

Prior to this visit we had attended meetings with the local placing authority, the local safeguarding team and the provider to discuss concerns about how some people's care and welfare needs had not been properly protected. These were being investigated by safeguarding team.

We found the provider responded appropriately to any allegation of abuse. Our records showed that the manager had made appropriate referrals to the local authority safeguarding team, the commission and had taken action, where necessary, to protect people.

For example we found improvements had been made to the security of the premises to ensure vulnerable persons could not leave the home without support. New alarms had been fitted to all fire exit doors. These could be differentiated by staff from the nurse call system. A new key pad locking system had also been provided on the external front entrance door. The provider confirmed that there had been no further incidents of vulnerable people leaving the service unescorted.

We asked four people who used the service if they felt safe living at Holy Name Care Home and each person answered, "Yes." Other comments included, "Very kind staff" and "Staff are always willing to help, nothing is too much bother for them."

Observations of staff interaction with people identified that they were polite and respectful when providing support and communicating with people.

The provider had policies and procedures in place about protecting people from abuse which referred to the Hull city council policy. The nurse manager confirmed that a safeguarding reporting flow-chart was posted on the staff room wall for their information.

We spoke with the five staff on duty about the safeguarding arrangements at the service.

We found that some staff we spoke with did not demonstrate a clear understanding of the type of concerns they should report and what might constitute a safeguarding concern. We also found that some of the staff could not tell us who they would report concerns to if they needed to raise anything outside the home.

Some of the staff, but not all, had received training about safeguarding people. Some staff told us the training had been some time ago and other staff said that they had completed the course when employed elsewhere. We reviewed the training records and found these had not been updated with recent courses the staff had attended. We were given information that six staff had completed the course; however records showed some staff had not completed the full course and others had not recently completed any refresher training.

Safety and suitability of premises ✖ Action needed

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 used the service, staff and visitors were not fully protected against the risks of unsafe premises.

We have judged that this has a moderate impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

We reviewed this outcome following concerns received about the effective management of some maintenance systems in the service.

The service provided facilities on two floors built around an existing church site. We toured the building and saw a sample of individual bedrooms, all of which had en-suite shower and toilet facilities. The provider explained that 28 of the 64 rooms were occupied and some of the rooms had been empty since the home opened in October 2012.

We found areas of the home to be clean, tidy and smelled fresh.

We saw people's rooms had been personalised to reflect their choices, this included personal mementos, pictures and small items of furniture. All the people we spoke with confirmed they liked their accommodation and could not tell us anything they wanted to improve. One person described how they had asked staff to change their room layout the previous day as they didn't like the position of the bed. The person confirmed this had been done; they were pleased with the new arrangements which made the room feel more spacious. A visitor we spoke with was complimentary about the cleanliness of the home. They told us, "They keep the home very clean, no odours or clutter."

The kitchen facilities and food safety systems had been assessed by the local authority environmental health officer as 'five star.' We saw that systems were in place to ensure the food was stored and served at appropriate temperatures There were records of temperatures for the refrigerator, freezer and cooked foods. These showed that staff were monitoring temperatures, so that people received their food safely.

Risk assessments had been completed in relation to the premises. The nurse manager explained how they monitored environmental risks and the checks they carried out on areas such as: hot water temperatures, fire safety systems and bed rails.

We saw that regular checks of hot water temperatures had been completed and showed

that these were generally at acceptable levels. The maintenance person showed us how they recorded when the thermostatic valves had been adjusted and the water temperature re- tested. The maintenance person identified that the record format would benefit from review and confirmed they would request this from the manager. We tested some of the hot water outlets and found the water to be at an acceptable temperature.

We found fire safety records were in place to support regular checks and testing of fire safety equipment in the home. Records showed fire drills had taken place regularly.

The nurse manager confirmed and records identified that a number of people had bed rails fitted to their bed which they used regularly. Following the inspection visit, the acting manager provided records which supported safety checks on bed rails were carried out.

During this visit we checked the maintenance systems in place to support the safe management of the water supply at the service. We found there were no records of any regular maintenance work carried out to flush water systems where the outlets were not used frequently, or not used since the service opened. The maintenance person confirmed that some outlets had been cleaned and flushed but not all and no records had been maintained of this work. Therefore the provider had failed to carry out required procedures to ensure that the water supply was safe for people to use. This had put the health of people who use the services and staff at risk of harm.

A policy was in place which identified the measures which should be taken to safely manage the water system in the service. We asked to see the service's current risk management plan and risk assessment for the water system. We found the risk assessment was dated 20 September 2013 and identified 'low' risk; this had not been reviewed and updated since the positive test results had been received. Nor did it reflect any of the action taken by the provider in respect of the test results.

There was no maintenance programme in place to support the current checks of the water system such as: boiler temperature, cleaning of shower heads, flushing of outlets and water testing which must be carried out to ensure the future safety of the people who used the service and staff who worked in the service. The nurse manager confirmed that this would be addressed as a priority.

Notification of other incidents ✖ Action needed

The service must tell us about important events that affect people's wellbeing, health and safety

Our judgement

The provider was not meeting this standard.

The provider had failed to notify the commission of an incident which affected the running of the service within the required timescale.

This is being followed up and we will report on any action when it is complete.

Reasons for our judgement

Our records and records kept at the service showed that we had been notified about some incidents that had occurred at the service appropriately, such as deaths and safeguarding concerns.

However, we found that we had not always been notified about other incidents that had occurred at the service within an acceptable timescale.

It is a legal requirement for us to be notified about these events, so that we can monitor services effectively and carry out our regulatory responsibilities.

On the 8 October 2013 we had been informed by the placing authority that there had been concerns reported about the safety of the water system at the service. We received a statement from the provider on the 9 October 2013 that testing had showed some positive results and they had taken action to make people safe. They had secured the necessary rooms to prevent access and the water systems had been treated. The statement the provider sent to us detailed that the routine water tests were carried out on the 23 September 2013 and the positive test results had been received by the provider on the 30 September 2013.

We received formal notification of this incident on the 8 October 2013 which detailed the action taken by the provider in response to the test results. The provider had failed to notify the commission the outcomes of water tests and subsequent action taken to protect people in the service within the accepted timescale.

Notifications – notice of absence ✖ Action needed

The service must tell us how they will manage the service safely when the person in charge is away

Our judgement

The provider was not meeting this standard.

The provider had failed to notify the commission of the registered manager's absence within the required timescale.

This is being followed up and we will report on any action when it is complete.

Reasons for our judgement

At this inspection we were informed the new acting manager was on leave and we were supported during the visit by the recently appointed nurse manager and the provider.

Following this visit, we received notification on the 9 October 2013 about the registered manager's absence. This detailed that the registered manager had been absent from the service since the 1 August 2013.

The notification provided details of the new management arrangements which had been put in place.

It is a legal requirement for us to be notified about this event within the required timescales, so that we can monitor services effectively and carry out our regulatory responsibilities.

This section is primarily information for the provider

Action we have told the provider to take

Compliance actions

The table below shows the essential standards of quality and safety that **were not being met**. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activities	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	**Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010** **Care and welfare of people who use services**
	How the regulation was not being met: Care and treatment was not always planned and delivered in a way that was intended to ensure people's safety and welfare. This was because care plans had not always been developed where care needs had been identified and they had not always been updated when care needs had changed. Risks to people's health and welfare were not always identified or adequately monitored. Regulation 9 (1)(a)(b)(i)(ii)
Regulated activities	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of	**Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010** **Safeguarding people who use services from abuse**
	How the regulation was not being met: People who used the service were not protected from the risk of abuse, because the provider had not taken reasonable steps to identify the possibility of abuse and prevent abuse from happening.

This section is primarily information for the provider

disease, disorder or injury	This was because some staff did not have a good understanding of the type of concerns which would constitute abuse and some staff had not received any training about safeguarding people. Regulation 11(1)(a)
Regulated activities	Regulation
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: People who used the service, staff and visitors were not fully protected against the risks of unsafe premises. This was because the provider had failed to carry out the required procedures to ensure that the water supply was safe for people to use and had failed to report the outcomes of water tests to the relevant authorities. Regulation 15 (1)(c)

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

CQC should be informed when compliance actions are complete.

We will check to make sure that action has been taken to meet the standards and will report on our judgements.

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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