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Maddalane Care Home

Inspection report

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Tel: 01752360253

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06 December 2016

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

The overall rating for this service is 'Inadequate' and the service remains in 'special measures'.

Services in special measures 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. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

We carried out an unannounced comprehensive inspection of this service on 05 August 2016. After that inspection we received concerns in relation to the management of the service, medicines administration, and the recruitment of staff. We were also told the temperature of the service was not always warm, and people were not being supported safely with their moving and handling needs. As a result we undertook a focused inspection to look into the concerns. 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.

Maddalane Care Home provides care and accommodation for up to 14 people. On the day of the inspection 11 people were living at the home. Maddalane Care Home provides care for older people. The provider managed the service and was registered with the Care Quality Commission. 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.

People's medicines were not always managed safely. The systems and process which were in place did not ensure people received their medicines in line with prescribing guidance. People were given time to take their medicines and staff showed respect and patience.

People were not protected from risks associated with their care. People who required support with their

mobility were not always supported by staff who had been trained to use equipment, such as hoists and stand aids. People's care plans were not always being followed.

People's healthcare needs were not always referred to relevant healthcare services in a timely manner. Risks associated with people's nutrition were not always managed to ensure they received responsive care and support.

People were supported by staff who had not been recruited safely to ensure they were of good character and safe to work with vulnerable people. The temperature of the environment was suitable, and daily checks had been put in place to ensure it was to people's satisfaction.

The provider was not always open and transparent during our inspection. This did not reflect the requirements of the duty of candour. The duty of candour is a legal obligation to act in an open and transparent way in relation to people's care and treatment.

The provider did not have effective quality monitoring systems to help identify when changes to people's care occurred and when action was required. Quality monitoring systems were not in place to help develop and improve the service.

The provider had not always informed us of significant events in line with their legal obligations, for example we had not been informed that someone had sustained a fracture.

After our inspection because of identified concerns we contacted the local authority safeguarding team. The local authority took immediate action to ensure people's health, safety and wellbeing.

We found breaches of the regulations. You can see what action we told the provider to take at the back of the full version of the 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?

Inadequate

The service was not safe.

People's medicines were not always managed safely.

People were not protected from risks associated with their care.

People were supported by staff who had not been recruited safely to ensure they were of good character and safe to work with vulnerable people.

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

Is the service well-led?

Inadequate

The provider did not have effective systems and processes in place to help monitor the quality of care people received.

The provider was not always open and transparent during our inspection.

The provider had failed to notify us of all significant events in line with their legal obligations.

We could not improve the rating for 'well-led' from Inadequate because to do so requires consistent good practice over time. We will check this during our next planned comprehensive inspection.

Maddalane Care Home

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.

We visited the care home unannounced on 06 December 2016. The inspection team consisted of two inspectors and a pharmacy inspector.

Before our inspection we reviewed the information we held about the home. We reviewed notifications of incidents that the provider had sent us since our last inspection. A notification is information about important events, which the service is required to send us by law. We spoke with the local authority safeguarding team and Commissioners.

During our inspection, we spoke with six people living at the service, one visitor, three members of care staff, a house assistant (domestic/helper), the chef, the deputy manager, the business manager and the provider. We observed care and support in communal areas and people's lunch time experience. We spoke with people in private and looked at eight care plans and associated care documentation, 11 medicine administration records (MARs). We assessed the environment for safety, and looked at staff recruitment and training records.

After our inspection because of identified concerns we raised safeguarding alerts as needed with the local authority. We also contacted local authority Commissioners, a GP practice and an occupational therapist.

Inadequate

Is the service safe?

Our findings

Prior to our inspection we received information of concern, relating to the management of people's medicines, the recruitment of staff, the temperature of the environment and how people were supported with their mobility.

People's medicines were not always safely managed. It was not always possible to determine if people had received their medicines as prescribed, because medicine administration records (MARs) did not match the amount of medicines in stock and MARs had not always been signed.

Some medicines were prescribed for people to take when required, such as paracetamol. However, there was no guidance for staff to show when these medicines might be needed or the required interval between doses. This meant people may not been be receiving their medicines when necessary.

People who chose to self- administer their medicines were not supported to help ensure associated risks were mitigated. For example, one person self-administered an inhaler; however there was no risk assessment in place to make sure they were safe and able to use their inhaler effectively.

People who had been prescribed topical medicines (creams/gels) were not always having these applied. For example, care records were inconsistently completed and there was no guidance and direction for staff about where to apply each topical medicine.

People's medicines were not always managed safely. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were observed to spend time with people explaining what the medicines were for and encouraging them to take them. Staff had used their initiative and contacted the GP of one person who sometimes woke later in the morning. This had been to check if it was safe for the person to take their morning medicines at lunchtime and this had been agreed by the GP.

Suitable arrangements were in place for medicines that required additional security, and non-prescribed medicines were available to people, such as cough medicine and were administered according to guidance on the homely remedies list.

People were not supported by staff who had been recruited safely, ensuring they were suitable to work with vulnerable people. For example, Disclosure and Baring Service (DBS) checks had not always been applied for, employment histories had not always been obtained and references from previous employers had not always been requested. The provider told us they would carry out a check of all recruitment files and ensure safe recruitment practices were followed in the future. Following the inspection we were provided with evidence of DBS checks for all staff.

People were not always recruited safely. This is a breach of Regulation 19 of the Health and Social Care Act

2008 (Regulated Activities) Regulations 2014.

The temperature of the environment was reviewed to ensure it was warm enough; this had been in response to concerns which had been raised. People did not tell us they felt cold and at the time of our inspection, the temperature was warm.

People who were supported to mobilise were not always supported by staff who had been trained to use equipment, such as hoists and stand aids; and people's risk assessments were not always followed to ensure they remained safe. For example, one person's mobility risk assessment detailed they required the support of two staff at night time. However, we were told by the provider they were supported by one staff member. Decisions in respect of people's changing mobility needs had also not been discussed with external professionals, to ensure they were being supported safely. Following our inspection, an occupational therapist was asked by the local authority safeguarding team to carry out assessments of people's moving and handling needs, to help ensure they were being supported safely and in a way that met their individual needs.

Risks associated with people's healthcare needs were not always referred to relevant healthcare services in a timely manner. For example, one person's care records recorded they had experienced regular constipation, for two months. The provider told us that they had planned to contact the person's GP during the week, but had not done so yet. The person's GP also confirmed they had not been made aware of any concerns. Following our inspection, the person's GP was contacted by the provider.

Risks associated with people's nutrition were not always managed to ensure they received appropriate care and support. One person's weight recorded they had lost weight over three months and their nutritional risk assessment also stated they should have a fortified diet. However when we spoke with the person they confirmed they were not receiving this. The chef was also not aware of the person's weight loss and that a fortified diet was required. We spoke with the provider about this, who told us they had spoken with the person's GP, but they had forgotten to record their communication. However, when we contacted the GP practice they told us there were no records of the person's weight loss being raised. Following our inspection, the person's GP was contacted by the local authority safeguarding team.

The provider did not take responsive action in order to keep people safe. People's risks associated with their care had not always been assessed and documented to help staff know how to mitigate risks associated with people's care. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

Prior to our inspection we received concerns about the overall management and leadership of the service. This was in respect of the management of staff, and the provider's actions in respect of people's care and the management of medicines.

The provider was not always open and transparent during our inspection. For example, the provider was not always able to give accurate information about people's care. This did not reflect the requirements of the duty of candour. The duty of candour is a legal obligation to act in an open and transparent way in relation to people's care and treatment.

Since our last inspection, the provider continued to not have effective systems to help identify when changes to people's care occurred and when action was required, and quality monitoring systems were not in place to help develop and improve the service.

There were also still no effective systems in place to ensure care plans and risk assessments were in place, individualised, adequately reviewed and gave guidance and direction to staff about how to meet people's needs.

Some systems had been implemented to monitor the administering of people's medicines to help ensure they received them safely, and in line with prescription requirements, however these had not been effective in identifying areas requiring improvement.

The provider did not have systems and processes in place to ensure the ongoing monitoring and quality of the service. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had not always informed us of significant events in line with their legal obligations, for example we had not been informed that someone had sustained a fracture. We were also informed by the local authority that they had been prompting the provider to submit notifications, because of the provider's limited understanding. Since our inspection, we have received some notifications however; the provider continued to demonstrate a limited understanding by asking the Commission for frequent advice, about what notification to send.

The provider had failed to notify us of all significant events in line with their legal obligations. This is a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

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 19 HSCA RA Regulations 2014 Fit and proper persons employed Regulation 19 1 (a) 2 (a) 3 (a) The provider had not always carried out checks to help ensure staff members were safe to work with vulnerable adults, before allowing them to start working at the service.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents Regulation 12 (1) (2) (a) (b) (g) People's medicines were not always managed safely. The provider did not take responsive action in order to keep people safe. People's risks associated with their care had not always been assessed and documented to help staff know how to mitigate risks associated with people's care.

The enforcement action we took:

The Commission took action to cancel the providers registration on 21 November 2016.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12 (1) (2) (a) (b) (g) People's medicines were not always managed safely. The provider did not take responsive action in order to keep people safe. People's risks associated with their care had not always been assessed and documented to help staff know how to mitigate risks associated with people's care.

The enforcement action we took:

The Commission took action to cancel the providers registration on 21 November 2016.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17 (1) (2) (a) (b) (e) The provider did not have systems and processes in place to ensure the ongoing monitoring and quality of the service.

The enforcement action we took:

The Commission took action to cancel the providers registration on 21 November 2016.