Marsden Rock Care Limited

Hampshire Court

Inspection report

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Overall summary

We carried out an unannounced comprehensive inspection of this service on 12 and 13 November 2014. At which a breach of legal requirements was found.

The registered person had not ensured people were protected against the risks of unsafe or inappropriate care and treatment arising from a lack of proper information about them by means of keeping accurate records for each person.

After the comprehensive inspection the provider wrote to us to say what they would do to meet the legal requirements in relation to the breach. As a result we completed a focused inspection on 12 May 2015 to check that they had followed their plan and to confirm that they now met the legal requirements.

Shortly after the comprehensive inspection in November 2014 we received concerns in relation to the hot water system and the level of staffing. As a result we looked into those concerns during this focused inspection.

This report only covers our findings in relation to those requirements. You can read the report from our last comprehensive inspection by selecting the 'all reports' link for Hampshire Court on our website at www.cqc.org.uk.

Hampshire Court provided residential care for up to 50 people, some of whom were living with dementia. At the time of our inspection there were 12 people living at the home, all of them located on the ground floor. The upper floor of the home remained not in use due to on-going maintenance work.

The service had a manager, who had been in post since 20 April 2015. The manager had not yet begun their application to register with us. 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.

At the focused inspection on 12 May 2015, we found that the provider had completed some of their plan which they told us would be completed by 23 February 2015.

Care plans and risk assessments had been updated since the comprehensive inspection but many of the same issues remained. We found the provider continued to breach regulation.

Risk assessments had not been completed in full and many had information missing, including dates and signatures. Information in relation to the monitoring of control measures was often not recorded. Risk ratings had not always been accurately calculated so people had been assessed as being at a lower risk than they actually were. One person had a risk assessment for dehydration with the risk recorded as medium but, when following the instructions to calculate the rating it should have been high. This was the case on several other risk assessments.

Some people had two versions of the same document in place, often with conflicting and confusing information recorded. One person had two falls risk assessments, one rated the risk as very high the other as a medium risk.

Summary of findings

We found care plans contained confusing and at times contradictory information. Some care plans didn't always direct staff as to specific strategies to use for example for using hoists and slings or for supporting people when they were anxious or distressed.

We saw no evidence of specific care plans in relation to medicines. One person had a care plan in relation to inhalers but it was not clear from the plan whether the person self-administered or whether the medicine was managed by staff.

The manager told us work was ongoing in relation to the hot water system. New boilers had been fitted and workmen were due on the day of the inspection as two toilets still had excessively hot water when the hot water outlets were turned on and one toilet had no hot water at all. The manager added that they had spoken to environmental health who were happy that work was now almost complete.

The manager confirmed that they had sufficient staff to meet people's needs. Staffing during the day was two carers and a senior and during the night one senior and a carer. An additional domestic role had now been filled and we found the service to be clean and tidy with no malodours.

You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

We found that limited action had been taken to improve safety.

Risk assessments had been re-written but they were incomplete. Inaccurate calculations of risk ratings remained and we found two versions of the same risk assessments. This was confusing and documents often contained contradictory information.

Work had almost been completed to resolve the issues with the hot water system.

Is the service responsive?

We found that limited action had been taken to improve responsiveness.

Care plans had been re-written and were being evaluated on a monthly basis. We found that specific strategies on how to support people were missing from the care plans which left people vulnerable to receiving inappropriate care.

Information was at times disjointed and contradictory to the information contained in corresponding risk assessments.

Hampshire Court

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 undertook an unannounced focused inspection of Hampshire Court on 12 May 2015. This inspection was completed to check that improvements to meet legal requirements planned by the provider after our comprehensive inspection on 12 and 13 November 2014 had been made.

We inspected the service against two of the five questions we ask about services: Is the service safe? Is the service responsive? This is because the service was not meeting some legal requirements.

The inspection was undertaken by one adult social care inspector.

Before the inspection we reviewed notifications received about the service. Notifications are changes, events or incidents the provider is legally required to let us know about. We also spoke with local authority commissioners of the service.

During the inspection we spoke with the manager and a senior care staff member.

We looked at care records for four people, specifically the care plans and risk assessments.

Is the service safe?

Our findings

At the comprehensive inspection of Hampshire Court on 12 and 13 November 2014 we found that the provider had breached Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 (Records). People were not always kept safe. When we examined people's care records, we found risk assessments had not been completed correctly. People may have been at higher risk than was calculated on their risk assessments. This meant people were at risk of not having adequate control measures in place to support their needs.

At the focused inspection on 12 May 2015 we found the provider continued to breach this regulation.

Risk assessments had been re-written since the comprehensive inspection but they had not always been completed fully and accurately.

The risk assessment document led staff to record the potential hazard, the level of the hazard, the people who would be affected, the control measures that were already in place and the likelihood of harm occurring. There was further information to be recorded in relation to how people would be affected. The risk rating was to be calculated by multiplying the level of hazard by the likelihood of harm. There was a space to record any additional control measures which needed to be put in place to reduce the risk, who had been involved in the decision making, how the control measures would be monitored including who was responsible, their designation [role], the frequency of monitoring and the method to be used. The person completing the assessment was required to sign it and there was an instruction on each risk assessment stating, 'assessor's line manager must approve risk assessment.' We found the provider was failing to follow their own procedure for completing and approving risk assessments.

Information on the monitoring of control measures, who had assessed the risks and who had approved the risks was missing from risk assessments. Risk ratings had been calculated incorrectly on some risk assessments and on others it hadn't been recorded.

One person had a risk assessment in place in relation to oral infections and hygiene. The risk rating had not been calculated, the monitoring of control measures was blank. This risk assessment had been approved even though there was information missing and no indication of who had completed the assessment.

This person had a risk assessment in relation to weight loss. This stated the person should be monitored when they ate in their room but we saw no evidence on the risk assessment of why. The nutritional risk assessment had a score of 13 but we saw no evidence of how this had been calculated or what it meant. The weight at the initial assessment was blank but the document recorded the person as being obese. This contradicted the information on the weight loss risk assessment and care plan which indicated that the person was at risk from weight loss. We asked the manager and senior care staff about this. The senior care staff member said, "We try to document any weight loss." They added, "There's been no significant weight loss, [person's name] is difficult to weigh." We asked for clarification on whether the person had been assessed. They told us, "They are obese, it's been assessed by the GP." We saw no evidence of this assessment in the care records and found the documentation to contain confusing information.

We saw a risk assessment for skin integrity. The risk had been assessed as medium but there was no information on how the monitoring of control measures should take place and the assessor had not signed the document. This risk assessment did not mention the risk of pressure ulcers even though the person had a pressure ulcer risk assessment in their file. The pressure ulcer risk assessment had assessed the risk as being high. The inconsistency in rating the level of risk meant people may have been at risk from inadequate or overly restrictive control measures.

A risk assessment for choking identified the hazard as 'at risk of choking as not compliant with SALT assessment.' SALT is the speech and language therapy team. The hazard had been rated as two and the likelihood of the risk was also two but the risk rating had been calculated as six which was incorrect. The risk assessment stated 'I am aware of the risk' however the only people recorded as being involved in the decision making around this risk assessment was the previous manager, and it had not been signed by the person. We saw no evidence of the SALT assessment in the care records although there was some information on what constituted a 'soft diet'.

Is the service safe?

We saw a consent document which stated 'I am happy/ prefer that none of the detailed care plans are signed.' This had been signed on 24 May 2013. There was no evidence that this decision had been revisited and reviewed.

This person had a risk assessment for bed rails which was not dated. The sections for additional control measures, how to monitor the control measures, who the assessment was completed by and approved by were all blank. A second risk assessment for bed rails was at the back of the care record file and had been completed on 13 October 2014. This was fully completed and signed.

We saw two versions of falls risk assessments in this persons file. One assessed the risk on a monthly basis as being very high but there was a note to say 'remains immobile.' The other risk assessment recorded the risk rating as medium and had been calculated incorrectly. The significant variation in the assessment of risk meant this person was at risk due to the potential for ineffective and inappropriate control measures being in place. The control measures recorded on the risk assessment were, 'floor mat in place [sensor mat], observed by staff, stand aid used, two carers.' The sections on additional control measures, monitoring of control measures, assessed by and approved by were blank.

A mobility risk assessment was in place which stated the hazard as being, 'can sometimes be sitting on arms of chairs.' The control measures were, 'buzzer mat in place in bedroom, reclining chair in lounge.' The falls risk assessment stated the person was 'immobile' which was confusing given that they 'can sometimes be sitting on arms of chairs.'

Another person had an eating and drinking care plan and a risk assessment which stated they were at 'high risk of aspiration due to not complying.' The hazard was that the person drinks from taps in their bedroom and from any cups that are left in the building. The risk rating was recorded as six – medium which was incorrect based on the level of hazard and the likelihood of harm. The rating should have been calculated as nine, high risk. The people involved in the decision making was blank and there was no information on the monitoring of control measures. We saw no information on how the person failed to comply.

This person had a risk assessment in relation to respiratory problems. The potential hazard was a risk of chest infection and aspiration pneumonia. The risk rating had been assessed as high. The control measures in place were identified as monitoring for infection and informing the GP. How the person might be affected was chest pain, rapid heart rate, shallow breathing, coughing, sputum, hospitalisation and death. Additional control measures stated 'non-compliant with diet and fluids and is on close observation.' There was no information in relation to monitoring of the control measures and who assessed and approved the assessment were blank.

A choking risk assessment stated the potential hazard as the person was 'non-compliant with SALT assessment and at risk of choking to death and at risk of aspiration pneumonia.' The control measures that were in place were recorded as being the SALT assessment and a Deprivation of Liberty Safeguard. The additional control measures needed were recorded as, 'to have DoLS in place, to encourage SALT diet, observe drinking.' The information on how to monitor control measures, who the assessment had been completed by and who approved the risk assessment were blank.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke to the manager about the process for deciding if a risk assessment was needed. They said, "I am trying to re-write all the care plans. If a risk is identified through care planning as a hazard or risk we complete a risk assessment."

The manager told us, "I am just going through the first full audit and finding similar things. There's no consistency, no standardisation." They added, "We will get there, I don't have any administration staff and I am reliant on the seniors [senior care staff] who are working the floor, for information. I've only been here three weeks."

Is the service responsive?

Our findings

At the comprehensive inspection of Hampshire Court on 12 and 13 November 2014 we found that the manager was in the process of updating documentation but it had not been completed and on two people's records we found various formats of the same information. For example, on one person's records we saw they had two care plans for sleeping documented on different paperwork which was confusing as the information varied. We also found reviews had not always taken place. This meant staff may not have been able to respond effectively to the needs of people within their care. This was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 (Records).

At the focused inspection on 12 May 2015 we found that care plans had been re-written onto the same format for each plan of care and they had been reviewed monthly.

We found the provider continued to breach regulation.

One person had a care plan for pain management. The person was able to tell staff if they were in pain and had a regular dose of pain relief medicine as well as 'as and when required' tablets for the management of pain. The care plan did not state why the person may be experiencing pain or the reason for pain relief medicine. We saw no evidence of a risk assessment in relation to pain management.

This person had a care plan in relation to 'breathing.' This stated the person used an inhaler and would inform the senior care staff if they had any problems. It was not evident whether the person administered their own inhalers or whether the ordering, administering and recording of medicine was managed by staff. The evaluation of this care plan completed on 29 April 2015 stated, 'continues to use inhalers.' We asked the senior care staff to clarify if this person self-administered their inhaler. They said, "No, it's in the trolley and administered by staff."

This person had a plan of care for eating and drinking. The aim of the plan was to 'promote a healthy diet and reduce risk of weight loss.' This plan stated a speech and language therapy (SALT) assessment was in place but they weren't compliant with it. We saw no evidence on the care plan in relation to why this person had been assessed by SALT or what it meant in relation to their care. The care plan had been evaluated on a monthly basis and records stated, 'observe, offer a soft diet but doesn't comply, risk assessment in place.' We saw no evidence in the nutrition or weight loss risk assessment of an assessment of risk in relation to the person not complying with a soft diet. The senior care staff told us, "Yes, [person's name] is obese; it was assessed by the GP."

There was a care plan for privacy with an aim of 'I would like privacy when eating tea and supper in my room.' The plan was 'I know I am not compliant with my special diet. I wish to be observed from the corridor for choking. I will alert staff by pressing the buzzer if I start to cough, I don't want staff to sit and watch me eat, I prefer them to sit me upright and raise my knees.' There was no detail as to what the special diet consisted of or how to support if the person did choke.

We saw a skin integrity care plan which gave no specific information in relation to pressure ulcers, even though the person had a pressure ulcer risk assessment which stated they were at 'high risk.' The care plan had been evaluated in March 2015 and stated 'E45 applied to legs and feet. Applied to bottom if red. Pressure equipment in place.' We saw no evidence in the care plan or risk assessment as to what pressure equipment was in place or how it was to be used. The scheduled review for 27 April 2015 had not been completed.

One person had a care plan in relation to continence. It stated 'two staff to use the hoist to put me on my bed in order for me to use the skipper pan. One staff member is to change my pad.' There were no specific details in this care plan in relation to how to support the person with moving and handling. This care plan had been reviewed monthly.

The person's care plan for mobility identified they should be supported by two staff to use the hoist and bucket sling for all transfers. There was no detail for staff to follow on how to use the sling. It did state that the person sometimes liked to attach the sling hooks to the hoist and that staff were to check they were fitted properly. There was no information for staff on how to check that the correct hooks had been fitted to the hoist.

A care plan for washing and dressing was in place. The corresponding risk assessment stated that the person used a bath hoist. The care plan did not detail how to use a bath hoist to support the person. This potentially left the person at risk.

Is the service responsive?

One person had a care plan and risk assessment in relation to dehydration. The care plan identified that the person often declined drinks or poured them onto the floor. Staff were directed to 'offer assistance' which included where to place the cup and to offer verbal prompts. It also stated a food and fluid chart should be completed but neither the care plan or risk assessment included guidance on the amount of fluids they should be supporting the person to drink. This left the person at increased risk of dehydration.

We saw a care plan in relation to sleep. This stated that the person was to be assisted by two staff and used a stand aid hoist, airflow mattress, bed rails and covers and was to be checked every hour. It recorded that the person could become agitated and aggressive. We saw no information in the care plan in how to support the person to have a good night's sleep. We saw no evidence in this person's file of a recorded capacity assessment or authorised deprivation of liberty safeguard for the use of bed rails. There were no specific instructions for staff to follow in relation to how to use the stand aid hoist or to support the person with transfers.

A mobility care plan for the same person also stated they required two staff and the use of a stand aid hoist for all transfers with the use of a large sling. Again there was no specific detail for staff to follow in how to support the use of the hoist other than to explain what they were doing. This plan of care also stated that the person could become aggressive.

In relation to managing this person's distressed behaviour there was a care plan titled 'mood' and one titled 'behaviour.' The 'mood' care plan stated, 'There is no problem to [the person's] behaviour or triggers for their mood.' There was no evidence on this care plan of any strategies staff should use to reassure the person or manage the behaviour. We found triggers had been identified on the 'behaviour' care plan as had some support strategies, such as staff not standing directly in front of the person and trying to divert with music, dancing, or magazines. The senior carer staff told us, "[person's name] has been referred to the behaviour team. The strategy to use was medication but it knocked them out so it was stopped. Staff try to give space and leave them alone then go back." We saw no evidence that this was recorded in the care records.

Another person had a diet and eating care plan which recorded the identified need as 'has a SALT in place.' A SALT is speech and language therapy team. The care plan recorded that the person was 'not always compliant with diet.' The person had been assessed by SALT who had recommended a modified diet which included thickened fluids and pureed food. The care plan went on to state that the person sometimes refused their diet as they don't like pureed food. Staff were to observe at all times, encourage and offer an alternative. The care plan stated, 'close observation as drinks from taps – DoLS in place.' The observations were to be every ten minutes as the person was at risk of aspiration. The care plan did not contain any information about how the person failed to comply with the diet. We asked the manager about this who referred to the senior care staff who said, "It isn't that they don't comply. They will eat a pureed diet but will seek food out for themselves. [Person] is on ten minute observations as they try to get food and drinks." The detail of this information was not recorded in the care plan or risk assessment which left the person at risk.

This person also had a risk assessment in place for choking which referred to a DoLS being an existing control measure but also that an additional control measure needed was a DoLS authorisation. A DoLS care plan was in place, it stated DoLS in place due to attempt to leave the building and also for food and fluid. Staff are aware of DoLS and a copy is in the care plan." We saw a DoLS urgent authorisation for food and fluid which expired on 29 July 2014.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 17 HSCA (RA) Regulations 2014 Good governance The provider was not able to assess, monitor and mitigate the risks relating to the health, safety and welfare of people and others who may be at risk because of inadequate records, specifically risk assessments and care plans. Regulation 17(1); (2)(b)(c)

The enforcement action we took:
A warning notice was issued.