Haisthorpe House Care Limited

Haisthorpe House

Inspection report

139 Holgate Road
York
North Yorkshire
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Date of inspection visit: 12 February 2015
Date of publication: 13/04/2015

Ratings

Overall rating for this service	Inadequate
Is the service safe?	Inadequate
Is the service effective?	Inadequate
Is the service caring?	Inadequate
Is the service responsive?	Inadequate
Is the service well-led?	Inadequate

Overall summary

This inspection took place on 12 February 2015 and was unannounced.

At our last inspection of Haisthorpe House in July 2014 we found that people were not always treated in a respectful manner and were not always receiving safe, consistent care and support. We also identified that the provider had not complied with the law with regard to the Mental Capacity Act 2005 and the Deprivation of Liberty safeguards. We found people were not protected against the risks of being harmed by other people and nor were people protected from the risks of unsafe management of medicines. Furthermore we determined the home was dirty and uncared for and maintenance work needed to be done to the building in order to protect the health and safety of the people living, working and visiting Haisthorpe House. We found there were not always enough staff working, and those staff were inadequately trained and supported. Recruitment processes needed to improve to ensure that only suitably vetted people were employed to work at the service. We saw the provider did not have arrangements in place to monitor how the service was operating. This meant that no-one had identified that the service delivery was not good enough

Summary of findings

and therefore needed to improve. We issued three warning notices and eight compliance actions to the provider and told them that they must make improvements.

We also required the provider to submit regular updates to us to demonstrate the improvements being made. Furthermore the provider agreed to not admit any more people to the home, until the improvements had been made.

This inspection was to check that the improvements recorded in the provider's action plan had been made. However, as we identified a range of areas where improvements were required at our last inspection, we carried out another comprehensive inspection at this visit, looking at all aspects of the service delivery.

Haisthorpe House has been registered by Haisthorpe House Care Limited to provide personal care and accommodation for up to 30 people with a mental health illness and/or a learning disability. The home is a large detached mature house, located on Holgate Road within about 20 minutes walking distance from the centre of York. There are local amenities close by and the service is on a public bus route. There is very limited parking on site and nearby on-street parking is also quite limited.

On the day of our visit there were 24 people living at Haisthorpe House. One of those people was in hospital.

There was no registered manager of Haisthorpe House. 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. The service has been without a registered manager for about three months.

We found overall that there was little noticeable improvement to the different areas where improvements were needed. Staff at the home and a professional who visited the service told us the staffing levels had improved, but the rotas sent to us following the inspection did not clearly identify who was working on each shift, and what their role was, so it was difficult to verify these comments.

The provider also told us in their action plan following the last inspection that the actions to address the cleanliness of the service, the environment, staff training and the staffing levels would not be completed until 31 March 2015. However, because of the continued and wide-ranging concerns we have again reported on these in this inspection report.

We found few areas of good care to report on. We found the care staff were kind and friendly, but they lacked direction and leadership. They provided people with choices, but there was no guidance for them to follow when people did not want the care and support they were offering. We noted the provider had also employed a domestic so that care staff could concentrate on their caring responsibilities.

We found the risk of harm to people was not well managed. People were not protected from incidents of abusive behaviour and these incidents were not reported to the right professionals. This meant no-one had the opportunity to look into these events and decide how best to minimise the risk of a similar incident happening again.

We found the risk of harm to people overall was not well managed. When staff recognised people were at risk, then this risk was not kept under review, to check whether the service was doing all it could to keep people safe. This meant people may be being exposed to a risk that could be avoidable.

We found robust recruitment checks were not carried out before new staff were appointed to work at the service. These checks were needed to ensure that there was nothing in an applicant's background that would make them unsuitable to work with vulnerable people.

Medicines were not always managed safely for people and records had not been completed correctly. People did not receive their medicines at the times they needed them and in a safe way. Medicines were not obtained, administered and recorded properly.

The fire safety risk management measures at the service were not good enough. Many of the people living at Haisthorpe House smoked and not all had safe smoking habits. This increased the risk of a fire breaking out there.

The environment at Haisthorpe House was poorly maintained. The health and safety of people living,

Summary of findings

working and visiting the service was placed at risk. Despite a domestic now being in post we found some areas of the home were dirty and needing more frequent cleaning. There was also a risk from passive smoking to non-smokers, as the smell of cigarettes was obvious in the communal areas of the home. Measures put in place to prevent the effects of passive smoking were ineffective.

The staff team had a poor understanding of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). They also had a poor understanding of their responsibilities of supporting people who were being cared for in the community under an order of the Mental Health Act 1983 Code of Practice (MHA). This meant people's mental health and welfare may be being put at risk and a person may be recalled back to hospital because the service had not supported them appropriately to comply with the order.

People's changing healthcare needs were not known and understood. This meant people could be at risk of harm because the service failed to respond promptly and appropriately to a new care need.

Whilst people told us they enjoyed the meals served to them at Haisthorpe House the service did not have a robust way of monitoring people's nutritional and fluid intake. This meant they could not evidence that some people were receiving sufficient food and drink to maintain their health and well-being. We also found that people's preferences and choices and their likes and dislikes were not explored with them. This meant the service could not deliver individualised care and support that was in line with what people wanted and needed.

The complaints process was ineffective as staff did not recognise and act, when an individual raised a concern. The provider did not ensure the complaints process was in a format that people living there could understand. This meant the service failed to respond promptly when people made a negative comment about the service they received.

The service was poorly led, with a lack of management support in the home. Day to day communication about people's needs was ineffective, which meant people's changing needs may be missed or not known. We noted care records did not provide good quality information about people's needs, or their preferences and choices.They were not updated when people's needs changed. The checks on how the service was being run were also ineffective as recent checks had indicated the service delivery was satisfactory. There was a lack of consultation with people living at Haisthorpe House about their care and how the service was operating. This showed a lack of respect towards the people living there and failed to value their contribution to how the service was being run.

We found the provider was in breach of thirteen regulations of the Health and Social Care Act 2008(Regulated Activities) Regulations 2010. These were in relation to care and welfare, safeguarding people from abuse, safety and suitability of the premises, cleanliness and infection control, requirements relating to workers, management of medicines, supporting workers, respecting and involving people, meeting nutritional needs, record-keeping, the management of complaints, obtaining consent and working within the requirements of the MCA and MHA and assessing and monitoring the quality of service provision.

You can see what action we told the provider to take at the end 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?
The service was not safe.

The service did not have measures in place to promote the safety and well-being of the people living at Haisthorpe House.

The overall risk of harm to people was not well managed and was not kept under close review.

Improvements needed to be made in regard to the management of medicines so that people get their medicines as prescribed and when they needed them.

Inadequate

Is the service effective?
The service was not effective.

Staff had a poor understanding of the law in relation to supporting people with mental health illness. This meant that people may not receive the support they needed, which may impact on their mental health.

There were not systems in place to ensure people's changing healthcare needs were known and understood.

Inadequate

Is the service caring?
The service was not caring.

Whilst staff were kind and friendly they lacked the leadership they needed to support people appropriately with their mental health needs and to promote people's independence and self-worth.

People's privacy and dignity needs were not always being addressed.

Inadequate

Is the service responsive?
The service was not responsive

People were not receiving a person-centred service. Their preferences and choices and their likes and dislikes were not explored with them. This meant they could not receive a service based on those individual needs.

The service did not have an effective complaints process that was understood and recognised by both people living there, and by the staff team.

Inadequate

Is the service well-led?
The service was not well led.

The service lacked leadership and management support. This meant the staff team did not have the day to day support they needed so that they could provide safe and appropriate care.

Inadequate

Summary of findings

The routine audits and checks on how the service was operating were ineffective and had failed to bring about improvement to the service delivery.

The provider was not actively consulting with people living there and with other stakeholders to determine what other changes were needed to the way the service was being run.

Haisthorpe House

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.

This inspection took place on 12 February 2015 and was unannounced.

The inspection team comprised four people. These were one adult social care inspector, an inspection manager, one pharmacist inspector employed by the Care Quality Commission (CQC) and the fourth person was a specialist professional advisor. This was an expert with a mental health background and was an Approved Mental Health Professional (AMHP).

Prior to the inspection we reviewed the information we held about the service, such as information about incidents that happened at the service, which the provider has to inform us about and information shared with us by other agencies. We spoke with a healthcare professional who regularly visited people who lived at Haisthorpe House and with the City of York commissioning team who had been carrying out their own monitoring visits to the service in recent months. We also looked at other records about the service kept by CQC, including documents that the provider was required to send to us each month to demonstrate how the service delivery was being monitored and improved.

We did not request a Provider Information Return (PIR) as this was an inspection to check whether failings, found at the last inspection in July 2014, had been addressed.

At the inspection we talked to ten people using the service and interviewed eight staff. These were the interim manager, two senior care workers, two support workers and two ancillary staff. Ancillary staff were people who worked at the service, but did not provided direct care and support. We looked at the care records for seven people and observed the way staff interacted with people. We also looked at a number of other records including medication assessment records, fire safety records, and other audits of how the service was operating. We looked at the overall environment and how well it was being maintained, including looking in many of the bedrooms

We also spoke with two visiting professionals who were coincidentally and independently visiting the service on the day of our inspection.

Inadequate

Is the service safe?

Our findings

We asked people whether they felt safe living at Haisthorpe House. We got a mixed response. One person told us they were contented and that staff treated them well. Another told us they had been kicked by another person earlier that day and did not feel safe as they were afraid of that individual. When asked they said they had not told anyone about this incident. We shared this comment with a member of the staff team, so they could talk with the person about it.

At our last inspection in July 2014 we found the service was not ensuring people's safety by making sure the risks of harm from abuse were being properly managed. We told the provider to improve this area of service delivery. At this visit we found continued concerns about the way abusive situations were managed. People living there overall told us they did not know who they would tell if someone hurt or upset them. We asked two workers about their roles and responsibilities around protecting people from harm. Whilst they showed some understanding about what abuse meant, and how this was to be reported, daily records over the previous month evidenced several incidents between people, where one had hit out at another. There was no record to show that these incidents had been recognised as abuse and followed up with the local authority safeguarding team, who take the lead in investigating these concerns. We also identified a number of medication failures during the inspection, where people had not been given their medication as prescribed. The service had not recognised these 'failings' and subsequently had not made the appropriate safeguarding vulnerable adults alerts.

We looked at the training records in relation to safeguarding vulnerable people. We found eight of the sixteen members of staff had completed safeguarding training in the past twelve months. Of the remaining eight the record indicated none had completed any training in this aspect of care since May 2012. Having a knowledgeable staff team helps to protect people from harm.

We asked staff what they would do if abuse happened on an evening or the weekend, or if the allegation was about a senior person. Their responses did not demonstrate a good understanding of the reporting procedures, both within the service and externally. We saw a safeguarding poster was displayed in the staff room, but this was out of date and included contact details for senior staff no longer working at the service. Our findings demonstrated a continued breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection in July 2014 we found the risk of harm to people was poorly managed. We found there were some generic risk assessments in relation to people's health care needs and the safety of the environment in relation to fire safety processes. However, we found these lacked detail and did not demonstrate any discussions with the individual, to show their views had been taken into account when the management of an identified risk was proposed. We told the provider to improve this area of service delivery.

On this inspection we asked staff about emergency arrangements at the service, outside of office hours. We were told the service had an on call arrangement involving the interim manager and two senior workers. One worker told us that if there was an allegation of abuse on an evening then they would call the person on call.

We asked a senior worker what they would do if they had a concern about the manager. They said they would discuss this with a colleague. We asked them what they understood by 'whistle-blowing' and why a whistle-blowing policy was important. Their response indicated they were unclear about this aspect of work. They did not know how to escalate a concern, in those circumstances.

We asked whether a worker would be able to contact the owner if they had concerns, or did not think a manager was behaving in a professional manner. The worker said they did not think the owner wanted staff at the service to know their contact details. They added that they did know the owner's contact details or where they could be found. This meant they could not raise a concern to the owner about the service, in those circumstances.

On this inspection we identified continued concerns around the way fire safety risks were being managed. We saw evidence in one person's daily records of two recent instances when they had failed to discard their cigarette end safely. There was no record of any review of these risks following the incidents, and no evidence of discussion with the individual, except to remind them not to throw away cigarette ends in that way, again. We saw fire safety monitoring checks were in place, but the records indicated

Is the service safe?

these were not always being completed in the required timescales. We also were told that one person required daily checks on their room for specific items in order to protect them from potential harm. We saw that these checks were not being completed, as required. A lack of robust management of the risk of harm to people meant people's care and support needs were still not being safely met.

At our last inspection in July 2014 we found there were not always enough staff working to meet the needs of people living there. There were no domestic staff employed so care staff had to carry out cleaning duties. We told the provider to improve this area of service delivery. At this visit we spoke with one person living there about the staffing levels. They told us they didn't get out much, but thought there was mostly enough staff working. They explained they had help with a bath twice a week and this was fine for them. Before our inspection a healthcare professional told us that staffing at the home had improved in recent months, in that the service now tried to cover short term absences. They explained that in the past if a worker rang in sick, then their shift often went uncovered. A worker we spoke with told us the domestic staff worked five days each week, and care staff carried out cleaning duties on a weekend. One worker we spoke with told us "We now have more time to spend with clients because we now have domestic support."

At our last inspection in July 2014 we found the service did not ensure robust recruitment checks were completed before new staff were employed. These checks were needed to ensure the applicant was suitable to work with vulnerable people. We told the provider to improve this area of service delivery. At this inspection we looked at the recruitment files for five members of staff. Some of these staff were working at the service when we last inspected, in July 2014. We found recruitment records were in place for three of these individuals. However the fourth person did not have a Disclosure and Barring Scheme (DBS) check and the fifth was working unsupervised with an old DBS from a previous employer. A DBS check is required to ensure the applicant was safe and suitable to work with vulnerable people. Following on from our last inspection the service had failed to check whether all the staff working at Haisthorpe House had been recruited in a robust manner and their backgrounds properly looked into. Our findings demonstrated a continued breach of Regulation 21 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010,which corresponds to regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection in July 2014 we found significant concerns about the way medication kept at Haisthorpe House was being managed. We found instances where people were not getting their medication as prescribed and the service did not have safe systems to ensure people received their medication appropriately. We told the provider to improve this area of service delivery. At this visit we asked if medicines were handled safely. We looked at the medicine administration records for 11 people, talked to staff and people living in the home.

We looked at how medicines were handled and found that the arrangements were not always safe. When we checked a sample of 'boxed' medicines for four people alongside the records we found they did not match up so we could not be sure if people were having their medication administered correctly.

Two medicines and one topical gel for three people were not available. This meant that appropriate arrangements for ordering and obtaining people's prescribed medicines were failing, which increased the risk of harm to people.

Records relating to medication were not completed correctly placing people at risk of medication errors. There were gaps on people's medicine records where the records had not been signed to show that the medicine had been taken as prescribed. If the dose had been omitted then staff had not recorded the reason for this. We saw for some medicines no record had been made of any quantities carried forward from the previous month. This was necessary so accurate records of medicines were available so that staff could monitor when further medicines would need to be ordered.

We found that records were not clear when the dose of a medicine was changed. For example one person was prescribed a medicine with a decreasing dose regime. It was not clear from the medicine administration record what dose was currently being administered and this meant that the person had been given an incorrect dose on a number of occasions.

One person had the same medicine available in both a bottle and in a blister pack supplied by the pharmacy. This

Is the service safe?

meant that they received an incorrect dose of this medicine on two occasions. We reported this concern to the local authority, for them to consider under their safeguarding vulnerable adults procedures.

The records which confirmed the application of creams and other topical preparations were incomplete. Incomplete record keeping meant we were not able to confirm that these medicines were being used as prescribed.

Medicines were kept securely. Records were kept of room and fridge temperatures to ensure they were safely kept in line with the pharmacy guidance.

Most of the people who used this service had their medicines given to them by the staff. We watched a senior carer giving people their medicines. They followed safe practices and treated people respectfully. People were given time and the appropriate support needed to take their medicines. One person was self-administering their medicines. A risk assessment had been undertaken to ensure they were safe to do so. However this was not reviewed regularly to ensure that this person was still taking their medicines as prescribed.

We looked at how medicines were monitored and checked by managers to make sure they were being handled properly and that systems were safe. We found that whilst the home had completed a medicine audit recently it was not robust and had not identified the issues found during our visit.

Our findings demonstrated a continued breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12(f) and (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection in July 2014 we found some aspects of the building were poorly maintained, which placed people living and working there at risk of harm. One person told us they did not feel safe as there was no lock on the front door, so anyone could walk in off the street. We also found at that time that environmental risk assessments were not in place. We told the provider to improve this area of service delivery. On this visit we found there was now a lock on the front door, to prevent access by unauthorised people. We also saw that some internal decoration of some communal areas had been completed.

However, we noted one external door was sealed off. Two members of staff explained to us separately that a chimney pot was unsafe and at risk of toppling in windy conditions, which was why they were stopping people using that door. Senior staff at the service on the day of our visit told us they did not know when repairs to the chimney were going to be made. Following our inspection we contacted a building Inspector who visited the service and spoke with the provider. The provider has informed us that this piece of work has now been completed.

We identified other concerns about the environment, which we discussed with an environmental health officer who has responsibility for health and safety matters in residential care homes. Although the service had a smoking area with an extractor fan, we found this was ineffective. The smell of cigarette smoke was apparent throughout the home, including the communal areas. Some people smoked in their rooms and we saw carpets with lots of cigarette burns in them. A staff member told us that five people living at Haisthorpe House did not smoke, and another worker thought two staff members did not smoke. This meant the service was particularly unsuitable for those people who did not smoke, as they were forced to be subject to the effects of passive smoking.

We looked at a number of people's bedrooms. We found two bedroom windows did not have window restrictors in place. This meant that those windows could be opened wide. This meant the service was not ensuring the safety of people living there, and particularly those people who may be at risk of self-harm. We saw a number of rooms were poorly maintained, with large cracks in the walls and/or ceilings. We saw trip hazards where the carpet was rucked up, or the floorboards were uneven. All these findings evidenced a building that was not being well maintained. Whilst the provider told us they would not be compliant to this regulation until March 31 2015, our findings demonstrated a continued significant and serious breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection in July 2014 we found the home was dirty. Furniture and furnishings were soiled, there was cigarette ash and butts on the floors, and people did not get the help they needed to keep their rooms clean. Audits (checks), to demonstrate that the home was being regularly

cleaned were not in place. We told the provider to improve this area of service delivery. On this visit we found the service employed a domestic, who worked five days each week. We noted they were working on the day of the visit. We spoke with one person who spent a lot of time in their room. They said they liked to clean their own room and confirmed that staff offered to help them if they were not feeling well.

However we noted the house was still dirty. There was still ash on the floor in the lounge, which indicated someone had been smoking in that part of the home, which was not part of the smoking area. We noted one person was wearing a call bell pendant, to allow them to summon help in the event of a fall. We saw this was dirty with bits of old food stuck to it.

We looked in one person's room, at the request of the visiting professional. We found the room smelled strongly of urine, the bedding was old and stained with what looked like faeces and there were dirty items in their chest of drawers. The professional said they had raised concerns about the malodour with staff on a previous visit. This showed the service did not have systems to ensure those people identified as 'at risk' were given extra care and support in order to minimise the risk of harm from an infection outbreak.

We looked in another person's bedroom and saw the person used specialist equipment to help them manage their long term health condition. We saw this equipment was dirty with cigarette ash and general grime. A support worker told us this was cleaned every day, however there were no records to evidence this, nor any reference to this support need in the person's care records.

This showed the service did not have a robust system to ensure the risk of harm to the individual, from using this dirty item, was minimised. Whilst the provider told us they would not be compliant to this regulation until March 31 2015, our findings demonstrated a continued significant and serious breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12(2)(h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection in July 2014 we found the service did not have effective systems to identify, assess and manage the risks of harm to people. This placed people at risk of harm. We told the provider to improve this area of service delivery. At this inspection we found the risk of harm overall was still poorly managed. Whilst the service had completed a range of audits these were not effective as they failed to identify the concerns that we found. For example a medication audit had been completed in January 2015, but this indicated that overall medication management at Haisthorpe House was robust. We also found there was no apparent learning from incidents. This was evidenced, for example, by people who were continuing to be placed at risk of harm by the actions of other people living at the service. This was because the service was not responding to these incidents in a timely way, reviewing what they were currently doing to keep people safe and then introducing new measures in order to better protect people. Our findings demonstrated a continued breach of Regulation 10 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service effective?

Our findings

People we spoke with gave us mixed responses about the staff who worked at Haisthorpe House. One person said the staff were kind and treated them well. They said they thought the staff knew them and knew the help they needed. Another person though talked with us about something they were worried about. We asked them if they had told a member of staff about this, for them to try to sort it out for them. They told us "I don't think I can talk to the staff. They're very busy. I don't think anything would get done". We shared this comment with the senior person and, at the person's request, also spoke with their healthcare professional.

At our last inspection in July 2014 we found that staff were not being provided with the support to enable them to care for people safely and effectively. Whilst we saw that staff had completed a range of training, this had not always provided them with the right skills and knowledge to enable them to provide appropriate care that balanced the need for ensuring people's safety with the rights of people to take risks. Supervision of staff was managed informally. This meant there was no record to enable managers to follow up previous discussions, or check on the workers' understanding and knowledge. We told the provider to improve this area of service delivery.

On this visit we spoke with staff about people's care needs. Whilst they showed some knowledge about people's individual needs, their comments did not include any knowledge of managing people's distressed reactions and responses. For example we looked at the care records for one person who had threatened another person a few days earlier. There was no information about any triggers that might cause a person to become angry, or how to manage those behaviours should they arise, or what symptoms may indicate a person's mental health needs were relapsing and health care support was needed. This meant important information about people's care needs may be missed as the relevance of different symptoms and behaviours may not be recognised.

We asked one worker about the training they had undertaken since our last visit. They said they had completed a three day first aid training course, fire safety training, health and nutrition, dementia care training and medication management. We looked at the training records for that person and saw the records were an accurate reflection of what they had told us. However the service's training record for all the staff identified some concerns. For example the main cook at Haisthorpe House had not had any food hygiene refresher training for more than five years. And nine of the sixteen staff members, including a senior night carer had not completed any fire safety training since 2013. Having a well trained staff team in fire safety management was particularly important at Haisthorpe House because of the identified fire safety risks at the service, because of some people's smoking habits. Our findings demonstrated a continued breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 18(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff we spoke with told us they felt supported by the senior managers. They felt communication at the service had improved in recent months. One person said "We are having staff meetings again. The manager encourages us to speak up." They confirmed they had had an appraisal in recent months, but no supervision, to discuss their work and what areas of work were more difficult for them. This aspect of support for workers needed to be built on and sustained, so that staff's knowledge and experience could develop.

We looked at the training records in relation to Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). Whilst we saw that nine out of sixteen people had completed this training since our last inspection in July 2014, other records we looked at did not reflect this improved knowledge. People's records did not evidence that people's mental capacity was being considered when decisions about their care and support were being made. The Mental Health Act 1983 Code of Practice states 'It will be difficult for anyone to provide care for people with mental health problems if they do not have knowledge of the Mental Capacity Act.'

For example one person had recently had an infection causing deterioration in their general health. This was recognised by carers who offered to get the doctor on more than one occasion. Each time the individual declined this support. The records of these discussions did not reflect whether care staff had considered the person's mental capacity, and whether this was impaired, due to their acute illness. This showed a lack of knowledge and understanding of the MCA and a failure to recognise the

Is the service effective?

importance of assessing people's mental capacity on each occasion. Our findings demonstrated a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 11 the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We were told that one person living at Haisthorpe House was subject to a DoLS. However, the visiting professional told us they had had to prompt and remind the service on several occasions of the need to apply for this. This indicated the service may not be alert to the circumstances where DoLS applications were required.

We looked at the way people's healthcare needs were managed and supported. A visiting healthcare professional told us a specialist doctor held 'surgeries' at the service every three weeks, because of the mental health needs of the people living there. They added that the service used to telephone for healthcare guidance and support very regularly in the past, but that these communications had reduced to 'almost nothing' in recent months. They expressed concerns as to whether people's changing needs and potential relapses were being spotted so readily as in the past.

We asked both the senior person in charge and a senior worker whether there was anyone living at Haisthorpe House who was subject to a Community Treatment Order (CTO). Both said there was no one there under that agreement. However, we found one individual who was subject to this order and who was seen by their community psychiatric nurse (CPN) on the day of the visit. A CTO allows suitable people to be safely treated in the community rather than under detention in hospital. Carers needed to be aware of that order and the agreed conditions of that order. This is so that they could report non-compliance, which may be a reason for a recall to hospital. The lack of awareness of this order, and its requirements, meant there was increased risk that the service was not supporting the individual appropriately, safely and in line with the requirements of the Mental Health Act 1983.

We found other concerns relating to people's mental health management. We saw one person was cared for under a Guardianship order, (Section 7 of the Mental Health Act) but staff did not respond in an appropriate manner when the individual wanted to leave the home. Similarly the staff did not follow reporting requirements when the individual was admitted to hospital. This demonstrated that the staff at Haisthorpe House did not understand their responsibilities in relation to caring for people in the community and safeguarding people's rights.

We also identified concerns about the way people's general healthcare was being managed. We identified one person with a recently diagnosed medical condition that may need emergency care. Whilst we saw this was recorded in the individual's daily records there was no plan of care relating to this emergency management. We asked one support worker about this, and then repeated the question to them, but they did not appear to know of it. This meant that they may not recognise and report the person's healthcare needs as requiring urgent treatment.

We saw from people's records that some people attended healthcare appointments independently, whilst others were helped to attend. We saw reference to chiropody support as well as general health check ups. However, we noted one person needed quarterly blood tests to check that they were on the correct medication dose. We saw that on a recent health review their doctor commented that this check had not been done, as required. This meant the service did not have good systems to ensure people's healthcare needs were being managed in a timely way.

We asked one person about their healthcare support. They told us "I've been to my GP this morning." When asked they commented "I don't know if the staff know I've been. No-one's been to ask how I got on (at the doctor's)." The service needed to know people's healthcare needs, to ensure they can meet those needs if the person was unwell and unable to manage these for themselves. Our findings demonstrated a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke with the person preparing meals on the day of the inspection. They showed a good understanding of people's dietary needs, and how these were to be met. However, they agreed that most of this knowledge was 'in their head' so if they were off work for a period of time, then this information would not be accessible to a stand-in cook. We found they understood how to fortify meals for those people with a poor appetite, to try to ensure they received an adequate nutrition. We noted there were salad items in the fridge, but mostly frozen vegetables were used.

Inadequate

Is the service effective?

We saw people had a care plan relating to their nutritional needs. We noted mostly that these were generic, that is, not individualised and specific for each person. We found that whilst people were being weighed, these were not being completed at regular intervals, to more readily determine whether people were losing weight. For example we saw one person had been weighed on 17/23 November; 7/14 (twice) December; 22 January and 8 February. We did not see any analysis of these weights, nor a reason for being weighed twice on 14 December. We noted their care record for 9 February stated "Poor diet and fluids taken. Nothing else to report." There was no indication as to whether staff had offered alternative foods, or extra snacks between meals, to try to supplement their diet.

A visiting professional expressed concerns to us about the monitoring arrangements of people's diet and fluid intake. We saw one person had recently been discharged from hospital with the guidance that they should try to drink two litres of fluids each day. There were no monitoring records in place, to determine whether the person was drinking sufficient amounts. We also noted there were no drinks available in the communal lounge. This meant people either had to ask for a drink if they were thirsty, or had to wait for staff to offer them one.

We observed part of the lunchtime to gain people's experience. We saw one person had been given an alternative meal as the cook knew they would not eat from the standard menu choices. This showed the service was flexible in supporting people to eat the foods they liked. However, we observed one person sitting on their own facing a wall, and slumped over the table for 10 minutes. We did not observe any staff sitting with the person, trying to engage with them, or encouraging them to eat their meal. This neither reflected a caring environment, evidenced appropriate or timely support nor demonstrated their dignity needs were being respected. Our findings demonstrated a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service caring?

Our findings

At our last inspection in July 2014 people gave us a mixed response about what it was like to live at Haisthorpe House. Some people were quite happy and contented, whilst others thought that some aspects of the service were inflexible. This meant the service was not always being run for the benefit of the people living there.

At this inspection many of the people we spoke with told us they were contented with their lives. One person told us "The staff are quite nice. They treat you the best they can." They added "Lately I've been getting breakfast in bed, because I've hurt my back." This indicated that people were now receiving a more flexible service, where their whole needs were being taken into account when care was planned. Another commented "I have a laugh with the staff. On the whole I get on ok with them."

However, we also noted in the minutes from the staff meeting held in December 2014 that the suppertime was changing to 19.30 so that night staff could get a handover. There was no reference to this change in the minutes of the resident's meeting, held in November 2014, to indicate people had been consulted about this, and were happy with the proposal. A lack of consultation suggested the service was being run to meet the needs of the staff, rather than the people who lived there.

We noted that some people did not look well cared for. Their clothes were dirty and stained and their hair was not brushed. A number of men needed a shave. We noted one lady had dry, coated lips. We saw minutes from a discussion group on 26 January 2015 that reported the lady saying 'Her lips were dry and she would like something to help.' So although she had asked for help, two and a half weeks earlier there was no evidence that this need had been met.

We saw from people's records that staff regularly offered choices to people and offered to help people with their personal care. However, we also noted that when people had declined this care there was mostly no record of what staff had done about this. Whilst we recognised that people had the right to decline care, we did not see reference in the care records we looked at, to evidence that staff had discussed with the individual the importance of maintaining good personal hygiene. We were told the service had a keyworker system, where people formed closer relationships with certain staff members. However, there was no evidence that staff used those relationships in a positive way so that people would be more likely to agree to personal care and changes of clothes when this was offered by their keyworker who they liked and trusted.

We read in people's care plans of other timers when people were not supported in a respectful way. For example one record stated "X's razor was a little blunt, but X shaved with it." Whilst the worker asked whether they could throw away the blade after that use, this indicated that the worker still thought it was alright to shave with a blunt blade.

We noted overall that staff spoke with people in a kind and friendly way. Whilst they tried to support people appropriately, they lacked understanding about people's mental health needs and the relevance of people's behaviours. We also saw some evidence that staff did not understand some aspects of people's care. For example we saw one person wore a call pendant and they told us this was so they could easily summon help if needed. However, a care worker provided that individual with another call bell that was attached to the wall, so that the person could use that, if necessary. This indicated the worker did not know what the pendant was for.

Despite the care staff's willingness to help people, and some positive comments from people living there, we found the areas of concern reported on in other areas of this report demonstrated that the quality of care provided overall was poor. Examples of this poor care included not keeping people safe, not ensuring people were given their medicines as prescribed and not ensuring monitoring records were in place and well maintained.

When we discussed the needs of the people living at Haisthorpe House with senior staff, we were told of one person's personal preference. However, when we looked in their care records we could find no reference to this preference, so could not determine whether this had any impact on the person's day to day life. If people's preferences are not discussed with people then the service cannot be sure that they are meeting people's needs appropriately.

We did not see much evidence of staff working in partnership with people to improve their life skills and independence. We saw from one person's records that they helped with preparing meals on occasions and they told us that they kept their room clean and tidy themselves.

Inadequate

Is the service caring?

However we saw another person's room was smelly and dirty and they were not able to clean this themselves. We did not see any evidence that people's abilities were being taken into account when care was being planned. We saw another person was prescribed creams and ointments for their long term skin condition. They told us they had to go to the treatment room twice a day to have their creams applied. This is a task orientated process, rather than person-centred care. There was no evidence that the service was working with the individual by supporting them to apply their own creams. Helping people to complete tasks for themselves promotes the individual's independence and self-esteem.

We observed one male resident was walking in the communal areas and his trousers fell down. Although staff were present, no-one rushed forward to protect his dignity or protect the other people in the room. Later in the day we saw the individual was still walking around, holding his trousers. There was no indication anyone had sought to address the problem. Our findings demonstrated a continued breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service responsive?

Our findings

At our last inspection in July 2014 we found people did not receive person centred care. This meant individualised care, in line with the person's assessed needs. We found when people's needs changed, their records were not always updated to reflect those needs. This increased the risk of people receiving unsafe or inappropriate care. We told the provider to improve this aspect of service delivery.

At this visit we found some people's care records had been re-written, to try to better reflect the care they needed. However, we still found that these records were basic and did not demonstrate they had been written in consultation with the individual.

If staff do not talk with individuals about their care then they cannot be sure that they are providing the care people want and need. A senior person told us that people did not want to be involved in their care planning records and that on those occasions staff made a note of that in the record. We did not see any evidence in the seven care records we looked at to show that people had been asked to be involved in their care plans, but had been either unwilling or unable to sign their agreement.

We did not see records relating to managing distressed reactions or responses, or what those behaviours may signify. Those records we looked at did not identify any 'triggers' that may cause a person to become angry or upset. If these triggers are not known or identified, then staff cannot work to avoid those situations. Similarly we did not see records relating to how best to communicate with people, or what different behaviours or mannerisms may mean. People with mental health illness often struggle to put into words their own needs and wishes, so people needed extra support to identify these preferences and choices so that these can be known and planned for.

All the care records we looked at included a template for people's life history. None of these were completed. When staff do not know or understand about people's past, then they cannot talk to them in a meaningful way, or provide social activities either within the service or the community that are of interest to them. This meant people were still not receiving a person-centred service.

We saw other concerns in the care records we looked at. Although there were some risk assessments in place, such as the risk of falling, or becoming malnourished because of a poor appetite, these had not been reviewed since October 2014. Regular reviews of risk were required to be sure that the service was doing all it could to manage that risk.

From looking at people's daily records we identified three people with general healthcare needs. We spoke with one person about this aspect of their care and they told us staff supported them in the way they wanted. However there was no care plan written about this care need and how it was to be met. Care plans are required so that people receive safe, consistent care, regardless of which worker is delivering that care.

We noted another person had a long-standing wound that was being treated by a community (district) nurse. Whilst the nurse maintained their own records relating to the actual care they delivered, there was no reference to this wound in the person's care plan. This meant there was no guidance telling staff what they needed to do should there be a problem with the dressing, in between the nurse's visits. We did not see any reference to this in the person's daily records so could not tell whether the dressing was still in place.

We also identified a third person with a recently diagnosed health condition that may require emergency treatment. There was no plan of care in their records to describe what staff were to do should the individual complain of symptoms that needed to be urgently managed. This meant that in that situation the person may not get the right care and support because different care staff may respond in different ways. Care plans were needed so that care staff had clear guidance to follow in those circumstances. People's records needed to be regularly reviewed, up to date and provide an accurate account of the care and support people needed. Our findings demonstrated a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17(2)(d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People we spoke with gave mixed comments about the social activities at the service. One person told us they were going abroad for a few days later in the year, with a care worker. They added that were looking forward to this. Other people living at Haisthorpe House go out into the

Inadequate

Is the service responsive?

community independently and we saw evidence of this in people's records. One person had enjoyed a trip to the pantomime, and another had gone to the post office and the local shops.

We asked one person whether they had a keyworker, with whom they had a closer relationship. They told us "I don't think I have a keyworker. I used to get on well with A. They took me out to places. I went out for a meal with them. We seem to have lost that (keyworker system) at the minute. I don't know why."

We asked people what they would do if they had a concern, or wanted to make a complaint about something. We got a mixed response. One person said they would tell the interim manager, however they had also told us a short while earlier that they thought the staff were very busy. They said there was little point in reporting their concern, as shared with us, as they did not think it would get addressed.

We noted another person's daily record stated on 9 February 2015 that they were "Agitated and shouting and swearing." When the worker spoke with them about this they said "Someone had pinched their jumper." There was no record of what had been done about this. A third person told us that another person had kicked their leg earlier that day. They said they had not told anyone. We asked a fourth person what they would do if they were unhappy about something. They did not know. We asked them if they would tell anybody. They did not know. The service needed an effective complaints process, that people knew about and trusted, and where negative comments were seen as concerns and were reported and looked into properly. Our findings demonstrated a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

At our last inspection in July 2014 we found the service was not well led. Checks on how the service was operating were not being routinely completed, the risk of harm to people was not being assessed, managed or kept under review, and the staff were not well supported. We told the provider to improve this aspect of service delivery.

At this inspection we found there was no registered manager employed, though the provider had employed an interim manager and an external consultancy team to bring about improvements to the way the service operated.

We noted the provider had been visiting the service each week and carrying out their own checks. They failed to identify the concerns we found. This indicated their checking process was not sufficiently robust.

Professionals we spoke with prior to the visit and on the day of the visit expressed concerns about the service and how it was being run. One told us they had to ask senior staff several times before their client got the care and support they needed. They added "I have struggled to get answers to queries. I've found it difficult to speak to the manager." The second professional told us that they thought the staffing arrangements had improved, but that the overall running of the service had not improved. They had not always found the senior staff receptive to their comments and concerns.

Although staff we spoke with told us that the service had improved, we found the care staff lacked leadership and management support. Communication within the service was poor and staff did not know key information about people's care needs or their legal responsibilities in terms of supporting people who were subject to the Mental Health Act 1983 Code of Practice. We noted the manager's office was sited in a separate building on the premises. This created an accessibility barrier for both people living at Haisthorpe House and the staff. This meant there was little opportunity for informal monitoring and observation of the quality of the care and support being provided.

However, despite the positive comments from the care staff, we found there were still serious concerns about the way the service was being run. We found a number of audits were now being completed, which suggested that the service had improved. However the findings from these did not match our findings. For example a medication audit had been completed in January 2015. The audit had identified some concerns, but mostly indicated that medication processes were working well. The pharmacist inspector found a range of concerns about the way medicines were being managed and some of these failures had impacted on people's health and well-being.

We saw an environmental audit had been completed in December 2014 that mostly indicated an improving service. We noted some re-decoration had been completed since our last inspection and that one bedroom was due for refurbishment. The senior staff we spoke with were unaware of any business plan as to the timescales when maintenance work to the building would be completed. However, we also found a range of concerns relating to fire safety and the maintenance and cleanliness of the building. Although the service now employed a domestic there was no indication that different areas of the service were being cleaned at different intervals, according to need. We noted one bedroom in particular was dirty and smelly but there was no extra provision to manage this. When a service is not kept clean and well maintained then people do not take a pride in living and working there.

We found that although the service had a smoking area with an extractor fan, this measure was ineffective. The smell of cigarette smoke permeated through the building, including the communal areas. This made it an unpleasant place to live and work, particularly for those people who did not smoke. We found the service had a fire risk assessment, but fire safety checks were not always being completed in line with the home's fire policy. This increased the risk of harm to people. We noted other areas where the building was poorly maintained, reported elsewhere in this report.

Following our visit we discussed our findings with the environmental health officer, the fire safety officer and the building inspector.

We also noted that although information about accidents and incidents at the service was now being gathered and recorded, these were not accurate as staff had failed to recognise, record and report some people's behaviours and responses as safeguarding incidents, that needed reporting to both CQC and the local authority.

Staff we spoke with told us that staff meetings had re-started in recent months. We were sent copies of the minutes from the two latest meetings in the days following

Inadequate

Is the service well-led?

our visit. These were from October and December 2014. We were also sent copies of the minutes from resident's meetings dated November 2014 and January 2014. We noted that changes to how the service was operating were discussed in the staff meeting and there was recognition that improvements were still required. Whilst we saw the residents made suggestions at their meetings, we did not see any action planning as to how those suggestions could be implemented. Nor were we shown any evidence of feedback to the individuals, and no follow up checks as to whether the changes had made a difference to the people living there.

We found the service had not taken the opportunity to find out what people living at Haisthorpe House thought about the service. One person told us they used to go to residents meetings, but don't go any more. They commented "They're very repetitive," then added "Nobody's ever talked to me about living here." Nor had the service surveyed the views of professionals who visit the service, or other visitors. Getting this information would give a better indication of the views of those people and would help to identify where improvements were needed. Our findings demonstrated a continued breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to 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 legal requirements were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care People who used services were not protected against the risk of receiving care or treatment that was inappropriate or unsafe. Regulation 9 (3) (b)-(h)

The enforcement action we took:
We are taking enforcement action against the provider

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect People who used services did not always have their dignity and independence assured because the provider had not made suitable arrangements to treat people with consideration and respect. Regulation 10

The enforcement action we took:
We are taking enforcement action against the provider

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent The consent of people who used services was not actively sought to ensure their human rights were respected and the requirements of the Mental Health Act 1983 and the Mental Capacity Act 2005 were being met. Regulation 11

The enforcement action we took:
We are taking enforcement action against the provider

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

This section is primarily information for the provider

Enforcement actions

People who used services were not protected against the risk of exposure to health care associated infections because the provider did not operate a system to assess the risk and prevent, detect and control the spread of infection. The provider did not maintain appropriate standards of cleanliness and hygiene in relation to the premises. Regulation 12(2)(h)

People who used services were not protected against the risks associated with unsafe use and management of medicines. 12(f)&(g)

The enforcement action we took:
We are taking enforcement action against the provider

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment People who used services were not safeguarded against the risks of abuse because the provider had not taken reasonable steps to identify the possibility of abuse before it occurred and had not responded appropriately to allegations of abuse. Regulation 13

The enforcement action we took:
We are taking enforcement action against the provider

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs People who used services were not always protected from the risk of inadequate nutrition and dehydration by means of the provision of support for the purposes of enabling them to eat and drink sufficient amounts to meet their needs. Regulation 14

The enforcement action we took:
We are taking enforcement action against the provider

Regulated activity	Regulation

This section is primarily information for the provider

Enforcement actions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment People who used services and others were not protected against the risks associated with unsafe or unsuitable premises because of inadequate maintenance. Regulation 15

The enforcement action we took:
We are taking enforcement action against the provider

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints People who used services were not protected from the impact of unsafe care and treatment because the provider did not have an effective complaints process. Regulation 16

The enforcement action we took:
We are taking enforcement action against the provider

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance People who used services were not protected against the risks of inappropriate or unsafe care and treatment, by means of the effective operation of systems designed to enable the registered person to regularly assess and monitor the quality of the services provided. Regulation 17. People who used services were not protected from receiving unsafe care and treatment because the provider did not maintain accurate records about the care needs of each person living there. Regulation 17(2)(d)

The enforcement action we took:
We are taking enforcement action against the provider

Regulated activity	Regulation

This section is primarily information for the provider

Enforcement actions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing People who used services were cared for and supported by staff that were not appropriately supported by the provider to enable them to deliver care and treatment safely to people because staff had not received appropriate training, professional development and supervision. Regulation 18(2)

The enforcement action we took:
We are taking enforcement action against 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 People who used services were not protected against receiving care and treatment from staff that were unsuitable to work in the service because the provider had not ensured staff were of good character and information about them specified in Schedule 3 was available. Regulation 19

The enforcement action we took:
We are taking enforcement action against the provider