Heartlands Care Limited

Heartlands Care Home Ltd t/a Lanrick House

Inspection report

11 Wolsley Road
Rugeley
Staffordshire
WS15 2QJ
Tel: 01889 577505
Website: www.example.com

Date of inspection visit: 14 January 2015
Date of publication: 27/02/2015

Ratings

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

Overall summary

This inspection took place on the 14 January 2015 and was unannounced.

At our previous inspection in August 2014 we found that the provider was not delivering care that was safe and met people's needs. There were insufficient staff numbers, people were at risk of infection due to poor standards of cleanliness of the home and the provider's quality systems were ineffective. We had begun enforcement action and had issued a notice of proposal to cancel the provider's registration.

The local authority was conducting a number of safeguarding investigations of suspected abuse and had suspended all placements into the service.

Summary of findings

At this inspection we found that standards in the delivery of care had not improved, people still did not receive the care and treatment they required. The provider had made some improvement in the cleanliness of the home and had increased the staffing levels. However staff were not trained to administer people's medication during the night time hours and people were not able to have medication that was prescribed to them. The provider's quality monitoring systems continued to be ineffective, care was not being delivered as planned and the provider remained in breach of a number of Regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Lanrick House is registered to care for up to 32 people who live with Dementia and physical disabilities. There were 14 people receiving a service.

There was a registered manager in post. 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.

People did not always receive their medication as it was prescribed. Some people were not able to have their medicines when they needed them due to there being insufficient trained staff to be able to administer them.

A large proportion of staff had not received safeguarding training and did not know the provider's whistle blowing procedure. Some staff we spoke with did not know what constituted abuse and who to report it to.

People were not always involved and had not always given consent to their care, treatment and support. The principles of the Mental Capacity Act were not always followed.

Staff were not always aware of people's assessed needs, information in care plans was not forwarded on to staff promptly. This left people at risk of receiving care that was neither safe nor effective.

Most interactions between staff and people were kind and caring. However we observed one person spoken to in a disrespectful manner. The manager was aware of issues around this person but they had not been addressed formally.

People's confidential information was not kept securely, private information was left in an area where it was visible to visitors.

Some activities were available but did not meet the needs of people with more complex needs. Some people spent long periods of time with little or no stimulus.

The provider had installed new flooring in the downstairs living areas, however it had begun to bubble up in areas and act as a potential trip hazard. The environment did not offer support to people living with dementia. There were no signs and physical prompts to orientate people to time, date and space.

Staff told us they felt supported but we found that they had not received the relevant training to fulfil their role effectively.

We found several continued breaches of Regulations of The Health and Social Care Act. You can see what action we have taken at the end 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. People were not receiving their prescribed medication as and when they needed it. There were insufficient suitably trained staff to meet people's needs. Some staff were unable to tell us what constituted abuse. Cleanliness and infection control measures were appropriate.	**Inadequate**
Is the service effective? The service was not effective. The provider did not consistently follow the principles of the Mental Capacity Act and the Deprivation of liberty safeguards. We found that there were restrictions imposed on people that did not consider their ability to make decisions for themselves. People did not receive care that met their assessed health care needs. People's nutritional needs were not always met and people were put at risk of harm due to being given the incorrect consistency of food for their assessed needs.	**Inadequate**
Is the service caring? The service was not consistently caring One person was spoken to in a disrespectful manner. People's confidentiality and privacy was not respected through secure record keeping. Staff spoke kindly about the people they cared for.	**Requires Improvement**
Is the service responsive? The service was not responsive. People's care was not personalised to their individual needs and people's cultural needs were not always fully met. There were activities available for people who were able to participate dependent on their needs. Other people were offered no stimulus throughout the day.	**Requires Improvement**
Is the service well-led? The service was not well led.	**Inadequate**

Summary of findings

The provider continued to be in breach of Regulations of The Health and Social Care Act 2008. The action plan the provider had completed stating how improvements would be made had been ineffective.

Lessons were not learned from previous incidents to minimise the risk of them occurring again.

Staff told us they felt supported however the provider was not ensuring that they were suitably trained to fulfil their role.

Heartlands Care Home Ltd t/a Lanrick 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.

The inspection took place on the 14 January 2015 and was unannounced.

The inspection team consisted of two inspectors and a specialist advisor who advises on dementia.

Prior to the inspection we had received information from the local authority. There were a number of safeguarding investigations being carried out at the home and the local authority were monitoring the quality of care on a daily basis due to the concerns.

During this inspection we spoke to eight people who used the service and observed their care, three visiting relatives, seven members of staff, the registered manager and the provider.

We looked at the care records for nine people who used the service, staff rosters, medication records and the providers systems for monitoring and improving the quality of the service.

Inadequate

Is the service safe?

Our findings

At our previous inspection we found that people were at risk of receiving care that was not safe due to there being insufficient, suitably trained staff to meet people's needs. At this inspection we saw that there were three care staff and a senior staff member in the morning and in the afternoon. We observed that people did not have to wait to have their care needs met as there were sufficient staff to meet their needs. However we were informed that there was no senior member of staff on night duty and none of the night staff were trained to administer medication if it was required.

Several people were prescribed 'as required' medication (PRN), such as pain relief medicines and inhalers. We saw that one person had become unwell in the night and staff had called their relative at 2.00 am to comfort them. The relative came to visit the person due to the concerns from staff. This person was prescribed pain relieving medication to take when required. As there were no trained staff on duty to administer their medication, records and staff confirmed that their relative gave them personal medication that they had with them. This meant that the provider was unable to meet this person's needs and medication was given which had not been prescribed to the person due to a lack of suitably trained staff.

One person was dependent on insulin to control their diabetes. This person administered their own insulin after staff had taken their blood sugar reading and had prepared the prescribed dose of insulin. Staff on night shifts had not been trained to complete this task. The person told us: "I have to wait for the senior to help me when they come on in the morning with insulin. I wake at 3am, have 3 cups of tea and then have to wait for the seniors to come on duty to do the blood sugars, have my insulin and then another wait until I have breakfast. This makes me anxious and I get stressed with the wait, sometimes I feel light headed". Staff and the manager confirmed that people had to wait to have their medication until the senior care staff came on duty at 8am. This meant that there were insufficient trained staff to meet the individual needs of people who use the service.

These issues constitute a continued breach of Regulation 23 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We asked the manager how other people who were prescribed PRN medication would be able to have their medication in the night if they needed it. The manager told us that most people would have had their maximum dose throughout the day so they wouldn't require any. There were no plans in place to support people to have their medication if they required it during the night time hours. We looked at the medication records (MAR) for people who required PRN medication for three weeks. We saw that some people were being administered PRN pain relief and inhalers on a daily basis up to the maximum dose. There were no records of why people had been administered the medication and there had been no review with the person's GP to inform them of the regular use of their PRN medication. This meant that people's needs in relation to their medication were not being reviewed and assessed as safe.

Following our inspection we were informed by the local authority that a safeguarding referral had been made for one person who had required their prescribed inhaler during the night. Paramedics had been called and night staff were unable to access the inhaler as it was locked away in the medication cupboard and they were unable to open it as they did not have the keys. There is an on going investigation into this incident.

One person had been prescribed a three day only course of antibiotics for an infection. We counted the tablets and saw that this person had begun a fourth day of medication on the day of our inspection. This meant that this person had been administered too much medication.

Another person told us they had not had their medication that morning and they were becoming stressed about it. They said "I am not having a good day today and haven't been able to have any medicine as it has run out". We checked to confirm if they had their medication and we were told by the manager they had not as the medicine had run out. We were told that the medication had arrived that day and had not yet been put out into the medication cupboard for use. We spoke with the manager who told us: "It wouldn't matter if they have their medication or not they will still complain". This meant that this person had not received their medication and suitable action had not to be taken.

These issues constitute a breach of Regulation 13 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Inadequate

Is the service safe?

We spoke to staff about how they kept people safe from the risk of abuse. Some staff were not able to tell us what constituted abuse other staff told us if they had any concerns they would report them to the senior member of staff on duty. Staff did not know if the provider had a whistleblowing policy and were not able to tell us what whistle blowing meant. The senior member of staff had not been informed how to raise a safeguarding referral with the local authority. There were times when this person was the most senior person on duty. Training records showed that a large proportion of the staff team had not received training in the safeguarding procedures. We had been made aware of incidents of suspected abuse which had not been reported by the provider. This meant that people were at risk of abuse not being recognised or reported in a timely manner.

This meant a there was breach of Regulation 11 of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2010.

There was no visible stimulus for people living with dementia to support them to orientate to time, date and space. There was no signage and all the bedroom doors looked the same with no prompts for people to know where their own rooms were. Bathrooms and toilets were not easily identifiable and there were no handrails in the corridor areas to support people to mobilise within the building independently. One person was visually impaired, we saw that their bedroom was stark and free from any sensory equipment. There were bags on the floor, which the person could have tripped over. Next to the head board were some hot water pipes which were not covered to prevent the person touching them. The manager told us that they had requested the handy person to complete this but it had not been done.

At our previous inspection we found that people were at risk of infection due to the cleanliness and infection control measures within the home. We looked throughout the building and found no areas of concern in this area at this inspection. We saw soap dispensers and paper towels throughout the building. We observed that staff used gloves and aprons when supporting people with personal care. Care staff who entered the kitchen area wore aprons and hats to ensure there was no cross contamination.

Inadequate

Is the service effective?

Our findings

Some people who used the service were living with dementia and lacked capacity to make certain decisions for themselves. The provider was not following the principles of the Mental Capacity Act by completing mental capacity assessments to ascertain who had capacity to decide and who required support to make decisions. The Mental Capacity Act (MCA) is designed to protect people who can't make decisions for themselves or lack the mental capacity to do so. One person had been recently admitted into the service and their assessment had stated that they had dementia. We saw that they were sharing a room with another person who was also living with dementia. The manager and provider were unable to tell us how these people had been involved in consenting to the decision to share a room and how it was deemed in their best interest.

We found that there were restrictions imposed on people that did not consider their ability to make individual decisions for themselves as required under the MCA. We saw that one person who had been assessed as living with dementia and had bed rails on their bed. There had been no mental capacity assessment completed to determine if this person was able to be involved in the decision about the use of bed rails. We asked the staff if they were being used and they told us they were. The provider told us that they were being used because the person had a double bed at home and they might fall out of a single bed. There was no risk assessment for the use of bed rails. There was no best interests decision to justify the restriction of this person's liberty. This meant the provider was not working within the MCA guidance and ensuring that this person was not being unlawfully restrained with the use of bed rails.

These issues constitute a breach of Regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) 2010.

Several people had diabetes. One person administered their own insulin after care staff had taken their blood sugar reading and drew up the prescribed dose in the insulin pen. We asked staff if they had received any training in diabetes care and they told us they had not. Staff told us they had observed other untrained staff before taking blood sugar readings and drawing up the insulin in the pen. We asked the senior staff what the 'healthy' blood sugar readings were for the person who required the insulin were and when there would be a cause for concern, they were unable to tell us and the person's care plan did not record it. The staff were not able to tell us what the signs were that their diabetes was not being managed effectively. This meant that the provider was not ensuring that this person's health care needs were being met.

These issues constitute a breach of Regulation 23 of The Health and Social Care Act 2008 (Regulated Activities) 2010.

One person had been recently admitted to the service. We asked if we could see the assessments and care plans for this person. It took two hours for the records to be located. The person had been assessed as living with dementia. We asked senior staff and care staff if they had seen the assessment and care plans and if they knew what this person's care needs were. None of the staff had seen the records and they were not able to tell us about the support the person needed. The senior staff member told us: "I would ask them what they wanted". Because of dementia this person would not have been able to respond to this question. This meant that this person was at risk of ineffective care due to staff not having the relevant information to be able to care for this person appropriately.

We saw in the care records that this person required a 'soft diet'. Their care plan did not state why they needed a 'soft diet'. The provider told us that it was because they had swallowing difficulties. We spoke to a member of staff about what they had to eat. One staff member told us: "They [the person] was not eating much when they came in. Now we've got them eating sandwiches and even crisps". We looked at the food recording charts and saw that non-soft foods were being given on a daily basis. This meant that the person's assessment did not accurately record why this person required a soft diet. This person was being put at risk of choking due to the wrong consistency of food being given.

One person's GP had recently reduced their blood pressure medication as they were having episodes of feeling unwell. We saw it was recorded that the GP had telephoned and asked the staff to take the person's blood pressure twice a week and inform them of the readings. We asked senior staff and the manager if this had been completed and they did not know this had been requested and had not been taking the readings as requested. This was two weeks after the initial request. The provider was not ensuring that this person's health care needs were being met by responding to a request from a health professional.

Inadequate

Is the service effective?

These issues constitute a breach of Regulation 9 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Some people had a do not attempt resuscitation order (DNAR). This is a legal order which tells a medical team not to perform lifesaving treatment on a person in the event of a cardiac arrest. We saw that these had been completed appropriately with involvement from the person's GP, the person themselves or their relatives. This meant that the principles of the MCA were followed in the completion of DNAR orders.

Requires Improvement

Is the service caring?

Our findings

People who used the service told us they liked the staff and they were kind and caring. A relative told us: "I have no real concerns, some staff are better than others, but I feel they should always be friendly and helpful". However we observed one person in the lounge attempting to stand up from their seat. A member of staff told the person in a firm tone of voice to 'sit down'. It was not recorded anywhere in their care plan that they could not stand up or it was not safe for them to stand up. We informed the manager and provider on the day of the inspection of our observations.

We saw that people's confidential records and medical prescriptions were visible in the corridor area, where visitors or other people could easily see or have access to them. Records were strewn across the desk in the same area with no consideration of what the records were and no respect for people's right to confidentiality. The manager agreed that they had thought the area looked 'untidy' when they saw it. The provider was not maintaining people's records, securely and confidentially.

This was a breach of Regulation 20 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Staff spoke kindly about the people they cared for. We observed that most interactions were positive and staff showed people respect when supporting them. At lunchtime we observed one person falling asleep at the dinner table, a member of staff gently supported them to wake up and encourage them to eat. When the person refused their meal, they were offered their dessert instead which they had and enjoyed, they then went onto eat their main meal. This meant that the staff were meeting this person's individual preferences.

Relatives were free to visit and told us they were kept informed about their relative's needs. One relative told us: "The staff are very good".

Requires Improvement

Is the service responsive?

Our findings

One person had specific cultural needs. This person was living with dementia. We saw that there were care plans informing staff of what their needs were, however staff told us they had not seen this person's care plans. It was recorded in a care plan and confirmed by their relative that this person required being able to wash their hands before every meal. We observed this person's care throughout our inspection and saw that staff did not support this person to wash their hands before being given their lunch. This meant the provider was not responsive to this person's individual cultural needs.

We observed that the television was set to a day time programme and saw that none of the people who used the service were watching it. People were either sleeping or sitting passively without looking at the TV. It was loud and overbearing. Two members of staff were sitting watching the programme and not interacting with people. Another member of staff started a game of bingo in the same lounge whilst the TV was still on causing a distraction. After a short while a member of staff turned the TV down but not off. In the care records we looked at we saw it was recorded for three people that they required stimulating activities. Some people were not able to join in with the bingo due to their complex needs. We observed that these people sat for long periods of time with no stimulation or interaction.

These issues constitute a breach of Regulation 9 of The Health and Social Care Act 2008 (Regulated Activities) 2010.

The provider had a complaints procedure. We were told that there had been no recent formal complaints made. The manager told us that there had been no recent relative or resident meetings and we could not see how people were encouraged to give feedback about the service they received. People who used the service were unable to tell us whether they were asked their opinion of the service they received.

Care records recorded people's likes, dislikes and personal history. However staff told us that they had not looked at people's care records in detail as they did not have the time. Staff told us they got to know people through verbal handovers and working with the person. From our observations staff did not know the needs of people as they were not meeting their assessed needs recorded in their care plans.

Inadequate

Is the service well-led?

Our findings

At our previous inspection we had found that people were receiving care that was not safe or suitable to their needs. We found that standards of care were not being maintained due to ineffective monitoring of care needs, insufficient staffing levels, ineffective assessment and unsuitable equipment. Care was not being delivered in line with people's care plans. People were at risk of infection due to the poor cleanliness and infection control measures. The manager and provider had implemented an action plan to inform us how they planned to make the required improvements. We had issued a notice of proposal to cancel the provider's registration, because these issues were continuing concerns from previous inspections with little evidence of sustained improvement.

The local authority were investigating a number of safeguarding referrals which had been made by external agencies and there was a suspension of admissions into the service for people who were being funded by the local authority.

At this inspection we found that the provider continued to be in breach of Regulations of the Health and Social Care Act 2008. The action plan had been ineffective in ensuring that all the planned improvements had been made and people were still receiving care that was not safe and suitable for their needs.

One member of staff spoke to a person who used the service in a disrespectful manner. When we informed the registered manager of what we saw, the manager knew who the staff member was and told us that they were aware of issues relating to this staff member. The manager had not begun to formally monitor the staff member's work practices despite their concerns, and the staff member was continuing to work with people unsupervised and without support. This meant that the provider was not addressing issues related to staff practices to ensure a quality service was being delivered.

Following the inspection we were informed that four members of staff had been dismissed without notice. We were informed that one staff member had been dismissed on our advice. The provider had not carried out an investigation into this staff members conduct prior to their dismissal.

One recent safeguarding investigation involved a person who had stopped eating and staff had not identified they were unwell. On the day of this inspection we found that lessons had not been learned from the incident. Staff still did not have the relevant knowledge to care for other people with the same specific health care needs that had related to the incident. This meant that the provider had not responded to minimise the risk to people with the same needs of a similar event happening again.

The provider had implemented an action plan following our last inspection telling us how they planned to maintain the environment and keep people safe. There had been some improvements made within the building . There was new flooring installed in the downstairs living areas, however it had begun to bubble up in areas and act as a potential trip hazard.

The environment did not offer support to people living with dementia. There were no signs and physical prompts to orientate people to time, date and space. One person with a visual impairment was at risk because no consideration had been given to their bedroom environment. This meant that the quality of the service was not being maintained to ensure that it met the individual needs of the people who used the service.

These issues constitute a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) 2010.

People's records were not kept securely. We had been contacted prior to the inspection by a solicitor who was acting on behalf of a previous person who used the service. Their relative was requesting records relating to the person through the Data Protection Act 1984. The provider had been unable to provide the records as they had not maintained them for a sufficient amount of time. This meant that the provider was not following the relevant guidance in relation to the retaining documents.

This was a breach of Regulation 20 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Staff told us they felt supported by the management and that they received regular support and supervision. There were minutes of staff meetings which recorded that staff were kept up to date with the current issues within the service and the areas which required improvement. This meant that the provider was keeping staff informed of the on going concerns however staff were still not delivering care that was effective and met people's individual needs.

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 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services The registered person did not take proper steps to ensure that each service user is protected against the risks of receiving care or treatment that is inappropriate or unsafe, by means of - the carrying out of an assessment of the needs of the service user the planning and delivery of care and, where appropriate, treatment in such a way as to meet the service user's individual needs ensure the welfare and safety of the service user

The enforcement action we took:
We had issued a Notice of Proposal to cancel the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision The registered person did not protect service users or others who may be at risk against the risk of inappropriate or unsafe care and treatment by the means of the effective operation of systems designed to enable the registered person to - regularly assess and monitor the quality of the service provided in the carrying on of the regulated activity identify and manage the risks to the health, welfare and safety and others who may be at risk carry out an investigation into the conduct of a person employed make changes to the treatment or care relating to analysis of incidents that resulted in or had the potential to result in harm to a service user

This section is primarily information for the provider

Enforcement actions

The enforcement action we took:
We had issued a Notice of Proposal to cancel the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff The registered person did not have suitable arrangements in place in order to ensure that persons employed for the carrying on the regulated activity are appropriately supported in relation to their responsibilities, to enable them to deliver care and treatment to service users safely and to an appropriate standard by - receiving appropriate training

The enforcement action we took:
We had issued a Notice of Proposal to cancel the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines The registered person did not protect service users against the risks associated with the unsafe use and management of medicines, by means of the making of appropriate arrangements for the obtaining, dispensing and safe administration of medicines.

The enforcement action we took:
We had issued a Notice of Proposal to cancel the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse The registered person did not make suitable arrangements to ensure that service users are safeguarded against the risk of control or restraint being - unlawful

This section is primarily information for the provider

Enforcement actions

	otherwise excessive

The enforcement action we took:
We had issued a Notice of Proposal to cancel the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment The registered person did not have suitable arrangements in place for obtaining, and acting in accordance with, the consent of service users in relation to the care and treatment provided for them.

The enforcement action we took:
We had issued a Notice of Proposal to cancel the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records The registered person did ensure that records were kept securely and located promptly when required retained for an appropriate period of time

The enforcement action we took:
We had issued a Notice of Proposal to cancel the provider's registration.