Lanemile Limited

Haven Lodge

Inspection report

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Ratings

Overall rating for this service	Inspected but not rated

Is the service safe?	**Inspected but not rated**
Is the service effective?	**Inspected but not rated**
Is the service well-led?	**Inspected but not rated**

Summary of findings

Overall summary

We carried out an unannounced inspection of this service on 23 August 2016. After that inspection we received concerns in relation to ineffective monitoring of healthcare needs for people who had a catheter, including identifying when a person's needs had deteriorated and taking necessary action. As a result we undertook a focused inspection to look into those concerns.

A focused inspection differs from a comprehensive because it is more targeted and focuses on areas relevant to the information received. Focused inspections do not usually look at all five key questions. We have not awarded a rating or changed the previous rating because we are not able to make judgements about all aspects of the service, which we must do in order to award an overall rating. We will return to the service to review improvements.

This report covers our findings in relation to this topic. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Haven Lodge on our website at www.cqc.org.uk

Haven Lodge is a residential and nursing home that provides care for up to 50 people who are elderly and frail with complex needs, including dementia and/or nursing related needs. There were 43 people using the service at the time of this inspection.

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.

We found that moving and handling practices were not managed safely and people were placed at potential risk of harm. Hoist slings in use to move people were not compatible with the type of hoist being used. Staff were observed using the wrong sized hoist slings which placed people at risk of discomfort or falling. Risk assessments and plans for people did not clearly specify the type of hoist and the correct type and size of sling each person required.

This was brought to the immediate attention of the registered manager. Following the inspection the registered manager informed us that action was taken to address this issue. Person-centred assessments were undertaken for each individual and plans put in place to adequately cover their moving and handling needs. We were told that each person has been provided with their own sling which is the correct size and compatible with the hoist they require, ensuring their comfort and safety.

In response to an incident where a person died, the provider had not met the requirements of Regulation 20 Duty of Candour and therefore did not promote a culture of openness and transparency. This included the actions they should have taken following the incident including investigating it, keeping the person's representatives informed of the investigation (on going or pending) and providing an explanation and/or

apology including any lessons learned.

Action had been taken to ensure the wellbeing of people requiring a catheter to maintain their continence needs. Staff had received training on catheter care and maintenance to ensure people's continence needs were supported safely. All catheter care interventions were clearly recorded. Care staff were aware of the importance of recording individuals' fluid intake and fluid output and recording had improved. There were systems in place to check records were being completed and people's daily fluid balance was monitored.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inspected but not rated

The service was not safe.

People were placed at potential risk of harm because moving and handling practices were not managed safely.

Moving and handling equipment being used were not compatible.

Risk assessments in relation to moving and handling people did not reflect the correct equipment required to move safely.

Is the service effective?

Inspected but not rated

The service was effective.

Peoples health care needs were being monitored and action taken when required. Records were maintained.

Is the service well-led?

Inspected but not rated

The service was not well led.

Systems and processes to assess, monitor and mitigate any risks relating to the health, safety and welfare of people were ineffective. They did not identify the risk to people in relation to moving and handling including staff training, risk assessments and, suitable compatible lifting equipment.

The registered provider and registered manager does not promote a culture that encourages candour or demonstrate a commitment to being open and transparent.

Haven Lodge

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 focused inspection took place on 19 April 2017 and was unannounced. A focused inspection differs to a comprehensive inspection because it is more targeted; looking at specific concerns rather than gathering a holistic view across a service.
The inspection was carried out by two inspectors.

We had received information which raised concerns about how people's healthcare needs were monitored including identifying that people needed additional support or care and taking necessary action. Before the inspection we reviewed information we held about the service. We had also received information from other stakeholders including the local authority safeguarding team, the police and the Coroner.

During the inspection we spoke with the registered manager, the deputy manager, the regional director and four staff members. We looked at care records for six people using the service. We also looked at other records and information relating to the management of the service such as staff training, policies and procedures and quality monitoring information.

Inspected but not rated

Is the service safe?

Our findings

People were placed at potential risk of harm because moving and handling practices were not managed safely. Risk assessments and care planning for individuals did not adequately cover the specific equipment they required to move safely. They did not fully identify the hoist or the hoist sling to be used. Hoist slings were not compatible with hoists; the colour coding for the slings did not match the colour coding key for slings stated on the hoists. This led to confusion for staff. Staff were not aware that sling sizes and coding varied between manufacturers.

We observed staff using slings that were the wrong size for the individuals they were moving and were incompatible with the hoist. They were unable to identify the size of the slings they were using and could not tell us if they were large or medium. Using the wrong type or size of sling can put the person at risk of discomfort if the sling is too small or falling if the sling is too large.

Management and staff told us that moving and handling risk assessments were carried out by the nursing staff. Manufacturers guidance was not followed resulting in inconsistency in the assessment of size of sling required. One staff member said they would measure from the head to coccyx [lowest part of spine]; another said the size was assessed by the weight of the individual. People's moving and handling needs were not reassessed in cases where there was weight loss which meant that people could be using a sling that was not appropriate or safe for their needs.

Staff told us that one of the hoists had recently been purchased; the other had been in use for more than a year. The registered manager told us that some new slings had been purchased. They later showed us that the slings had been delivered but not unpacked and that they would be putting these in place for use immediately.

We found that there were limited toilet slings available for people and staff told us that slings were being shared between people and washed monthly. Toilet slings should not be shared as there is a potential risk for cross infection.

This is a breach of Regulation 12(1) of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

Following our inspection the registered manager wrote to us to confirm that they had purchased more slings so that each person who required moving and handling equipment had their own personalised slings for moving and handling and toileting purposes. They also confirmed that each person's risk assessment and plan had been reviewed and updated to include the type of hoist and sling size they each required. This information was kept in people's personal folder, in their bedrooms and, was accessible to all staff. Staff were being reminded, in daily meetings, to consult the moving and handling plans prior to carrying out any transfers.

Inspected but not rated

Is the service effective?

Our findings

Staff had recently received training on catheter care and maintenance to ensure people's continence needs were supported safely. Care staff knew signs to be aware of in relation to blockage and infection. Documentation was in place which showed clear records of any interventions with regards to catheter care. This enabled an effective audit trail and communication for staff and other health professionals involved in the individuals care.

For people requiring a catheter for continence maintenance the measuring and recording of fluid intake and output is important for their wellbeing. The recording of fluid intake and output had improved but there were gaps in the totalling of the daily intake and output on some people's charts. The totals are important to identify any imbalance in fluid intake and output and potential emerging health risk such as a blockage, infection or dehydration. Fluid records were checked by the nurse in charge of each shift to ensure they were being completed and they totalled the daily intake and output amounts. The totals were recorded by nurses elsewhere on the computer system for monitoring purposes.

People in bed were supported to reposition to prevent pressure ulcers and there were records completed to monitor this. People's weight and dietary intake were recorded for monitoring purposes and to identify any risk of malnutrition. Appropriate action was taken when change in needs were identified such as the provision of nutritional supplements and fortified foods. Referrals were made to relevant healthcare professionals when further specialist guidance was required such as the mental health team and speech and language therapist.

The service had a positive focus on ensuring people were hydrated and not at risk of dehydration. Whilst this is good practice the approach was not person centred because each person was given a target amount of 1200 mls of fluid to consume over a 24 hour period. Their individual needs were not considered such as end of their life or long term health conditions. Staff followed the service procedure to alert the GP if the target intake had not been reached on three consecutive days. The deputy manager told us that the target amount was taken from the World Health Organisation (WHO) recommendation. However, the WHO guidance, dated 2004 recommends that the target intake should vary according to individual factors. The deputy manager said that generally staff should offer people a drink on an hourly basis and they were to include preferred or alternative drinks. However this was not recorded in care plans. During our inspection a GP visited an individual at end of life and told staff to support the person with drinks that they preferred as and when they required them, we were told that their care plan would be reviewed and changed to reflect this.

Inspected but not rated

Is the service well-led?

Our findings

The provider had governance systems in place which included auditing systems and processes to help to assess, monitor and drive improvement in the quality and safety of the service provided, including the quality of the experience for people using the service.

The systems and processes must also assess, monitor and mitigate any risks relating to the health, safety and welfare of people using the service, and others. Monitoring and governance arrangements in the service for moving and handling were ineffective. This included staff training, risk assessments and, suitable and compatible lifting equipment. Handling plans were not adequately reviewed to ensure they were current, relevant and include adequate information.

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

This inspection raised concerns about the provider's application of their Duty of Candour policy and procedure with regards to an incident following which a service user died. The incident is subject to a criminal investigation. We were told by the regional director that it was company policy not to commence an internal investigation and root cause analysis until the criminal investigation was concluded.

However the provider's Duty of Candour policy includes steps to be followed; the first one being as soon as a notifiable incident has occurred to notify and provide information and support to the person lawfully acting on the deceased behalf. The notification must include an apology and advise and explain the next process and how long this may take. The regional director and the registered manager confirmed that this had not been done. There are lessons to be learned with regard to effective communication and keeping relevant people up to date and fully informed in the interests of open and transparent communication.

This is a breach of Regulation 20 Duty of Candour of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Care and treatment was not provided in a safe way. The registered persons failed to assess the risks to the health and safety to service users and do all that is reasonably possible to mitigate any such risks.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered persons system for assessing, monitoring and mitigating risk relating to the health, safety and welfare of people using the service, and others was not effective.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20 HSCA RA Regulations 2014 Duty of candour The registered person failed to act in an open and transparent way and initiate their Duty of Candour policy when required.