Haverholme Care Home Limited

Haverholme House

Inspection report

Broughton Road
Appleby
Scunthorpe
South Humberside
DN15 0DA

Tel: 01724862722
Website: www.advinia.co.uk

Date of inspection visit:
18 February 2016
19 February 2016
22 February 2016

Date of publication:
03 June 2016

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

Summary of findings

Overall summary

Haverholme House is registered to provide residential and nursing care for up to 47 older people, some of whom may be living with dementia. Accommodation is provided over two floors with both stairs and lift access to the first floor. There are two units with a large range of communal areas. The home is situated in attractive grounds on the outskirts Appleby village, near Scunthorpe.

The service did not have a registered manager in post. An acting manager had been in post for 10 months and had submitted their application for registration, however during the inspection they resigned from their position and left the service. 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. A support manager had been employed at the service for two weeks prior to the inspection to help the acting manager develop their performance to the required standard to enable them to continue to run the service. Following the acting manager's resignation the support manager was appointed by the registered provider to take over the day-to-day management of the service.

This inspection was unannounced and took place over three days on the 18, 19 and 22 February 2016. The previous inspection of the service took place on 12 and 13 March 2015 and was found to be compliant with all of the regulations inspected. During the inspection there were 32 people using the service, two of whom had been admitted to hospital.

We found the registered provider was in breach of eight regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These were in relation to person-centred care, safe care, safeguarding people from abuse, staffing levels, training and supervision, obtaining consent and working within the requirements of the Mental Capacity Act 2005 (MCA), maintenance of the premises, complaints, and assessing and monitoring the quality of service provision. We also found a breach of Regulations 18 of the Care Quality Commission (Registration) Regulations 2009 for non-notification of serious incidents that occurred in the service. The majority of these breaches were assessed by CQC as high, as the seriousness of the concerns placed a risk of significant harm on the lives, health or well-being of the people who used the service.

We found risk to people such as falls, leaving the building, pressure damage, weight loss and the use of bedrails had not been assessed or managed properly. Measures had not been put in place to minimise risks and incidents and accidents had not been recorded and analysed to help find ways to reduce them.

Some people had not received health professional advice and treatment in a timely way and their changing health care needs were not known and understood by the staff. People were at risk of harm because the service failed to respond promptly and appropriately to new care needs.

Staff had not provided people with person-centred care that met their needs. Care plans contained some preferences for care but did not describe people's needs properly so staff did not have clear guidance in how to manage them. Communication regarding people's care was not effective to ensure staff were kept up to date with people's needs.

Whilst people told us they enjoyed the meals served to them at Haverholme House the service did not have a robust way of monitoring people's nutritional and fluid intake. Some people had lost weight but this had not always been recognised and followed up.

Safe staffing levels had not always been maintained and staff recruitment processes were insufficient. We observed routines were busy and disorganised at times and people experienced delays with care support.

Staff were not adequately supported to undertake their role effectively. We found many staff had not received appropriate supervision, appraisal and training to ensure they were confident, safe and competent to provide people with effective and safe care.

People who used the service and their relatives told us staff were kind and caring. We saw some positive interactions with staff and management treating people well, with dignity and respect. However, we found interactions were mostly task focused and there was a lack of stimulation and activities provided for people, especially those living with dementia.

There had been a failure to protect people from harm and to recognise and report when people had been put at risk or had been subject to harmful situations. There had been unacceptable delays in the provision of information to the local authority safeguarding team when requested and also delays in the completion of investigations into safeguarding concerns.

Safe systems were not in place regarding the ordering, administration, recording, stock control and return of medicines. The systems were inadequate and placed people at risk of harm.

We found people who used the service were subject to restrictive practices which had not been identified or managed in line with the MCA and the Deprivation of Liberty Safeguards (DoLS).

Although information about complaints was displayed around the service and available to people, we found effective systems to manage people's complaints were not always in place.

We found many parts of the environment required attention to make sure they were hygienic and maintained. There was no renewal programme in place.

We found serious concerns with how the service was managed overall by the acting manager and how well it was governed by the registered provider. There was no effective system in place to monitor the quality of the service people received. Although there was evidence of regular visits to the service by the regional operations manager, quality manager and CEO (Chief Executive Officer), there were few records to show how the acting manager was supported in their role or how the registered provider monitored the acting manager's practice to ensure they had the competence, skills and experience to manage the service.

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by CQC. The purpose of special measures is to:

• Ensure that providers found to be providing inadequate care significantly improve

• Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.
• Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will be kept under review and if needed could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

There had been a failure to protect people from harm and to recognise and report when people had been put at risk or had been subject to harmful situations.

Risk had not been managed effectively which had affected the safety, health and welfare of people and could have contributed to accidents and injuries.

People did not receive their medicines as prescribed. The recording of medicines was poor.

There were times when there were insufficient staff on duty to meet people's assessed needs. Staff recruitment processes were not robust.

Is the service effective?

Inadequate

The service was not effective.

Not all staff had received training, supervision and professional development to enable them to deliver care and treatment to people in the service safely and to an appropriate standard.

Suitable arrangements were not in place for people to consent to their care. Some people who used the service were subject to restrictive practice which had not been identified or managed in line with the Mental Capacity Act (MCA) 2005 and The Deprivation of Liberty Safeguards (DoLS).

Areas of the environment needed attention to ensure they were clean, safe and pleasant for people to live in.

People enjoyed the meals but their nutritional needs were not always monitored effectively.

Is the service caring?

Requires Improvement

The service was not always caring.

Although we observed staff treated people with kindness and spoke with them in a caring way, we found the care and support provided to people was tasked-based and not individualised.

People's dignity was generally respected although we observed care was rushed at times and also some people waited for assistance. Staff did not interact unless prompted and they did not have time to spend with people.

Is the service responsive?

Inadequate

The service was not responsive.

There was a lack of information within some people's care plans about their life histories and preferences with regards to their daily lives and their care needs.

People's needs had not been effectively assessed and plans of care had not been developed to provide full guidance in how to meet them.

Shortfalls in recording of people's care and communication of changes in their needs meant people's care needs were not always met.

Although there was an activity programme in place, there were insufficient activities and stimulation for some people living with dementia.

People told us they felt able to complain however their complaints were not always managed effectively.

Is the service well-led?

Inadequate

The service was not well- led.

There were no effective systems or processes to ensure the service provided was safe, effective, caring, responsive or well-led.

Although there was evidence of regular visits to the service by the regional operations manager, quality manager and CEO, the staff team and the acting manager had not made sufficient improvements to ensure people received safe and appropriate care. A support manager had been employed by the registered provider prior to the inspection to ensure safe and effective management of the service.

Notifications had not been made to the Care Quality Commission for all incidents which affected people's health and wellbeing.	

Haverholme 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 registered 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 18, 19 & 22 February 2016 and was unannounced. The inspection was led by an adult social care inspector who was accompanied on the first day of the inspection by another adult social care inspector.

Before the inspection, the registered provider completed a Provider Information Return (PIR). This is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make. We also looked at notifications sent in to us by the registered provider, which gave us information about how incidents and accidents were managed. We spoke with the local authority safeguarding team, and contracts and commissioning team about their views of the service.

We spoke with ten people who used the service and seven of their relatives who were visiting during the inspection. We observed how staff interacted with people who used the service and monitored how staff supported people during lunch. We spoke with three community nurses who visited the service during the inspection.

We spoke with the regional operations manager, acting manager, support manager, quality manager, HR manager, the administrator, two cooks, a domestic worker, two laundry assistants, deputy manager, three senior care assistants, three care workers and the maintenance person.

We looked at sixteen care files which belonged to people who used the service. We also looked at other important documentation relating to people who used the service such as incident and accident records and 31 medication administration records (MARs). We looked at how the service used the Mental Capacity Act 2005 and Deprivation of Liberty code of practice to ensure that when people were deprived of their liberty or assessed as lacking capacity to make their own decisions, actions were taken in line with the legislation.

We looked at a selection of documentation relating to the management and running of the service. These included four staff recruitment files, the training record, the staff rotas, supervision records, minutes of meetings with staff and people who used the service, quality assurance audits and maintenance of equipment records. We completed a tour of the premises.

Inadequate

Is the service safe?

Our findings

We received some mixed comments from people and their relatives about the cleanliness of the home, safety and the staffing levels. Comments included, "Very safe here, they treat us very well", "Our relative has been found outside on a couple of occasions, we have raised concerns about this", "The staff are kind and caring, but staff don't have time to engage properly with residents to promote their well-being", "Sometimes staff aren't easy to find and the lounge areas are unattended", "I often receive my morning medicines too late and there should be more time between the morning and lunch time rounds", "I can't keep track of them, a lot of the staff have left and we have to get to know the new ones. They don't have much time to spend with us, they are very busy", "The home seems generally clean and tidy" and "Yes, there are smells and not all areas are as clean as they could be but it's a very big place and they don't seem to have enough cleaners."

The numbers of staff on duty and the organisation of the shifts did not always provide people with timely care and support; there were times when people had to wait for support with personal care and toileting. We observed communal areas and people's rooms were not always adequately supervised and at times we had to request support from care staff to assist people with their care. The arrangements at mealtimes meant there were not enough staff deployed in the dining areas to ensure people who required assistance were supported appropriately.

Staff told us the dependency levels were high; most people living at the home needed two staff to help them get washed, dressed and get in and out of bed. Many people required assistance with eating and were at high risk of falls. All the care staff we spoke with told us there were not always enough care staff on duty to meet people's needs. They recognised the numbers of staff on shifts had been increased but staff sickness levels were high and the short notice absences were not always covered. One care worker said, "We regularly have days when staff ring in sick. We try and get this covered, if we can't we just have to manage. We are getting more staff now, but it has been difficult" and another told us, "We know there have been a lot of falls but we do our best to monitor people and keep them safe. This isn't easy when we are short staffed."

The regional operations manager confirmed the staffing levels had been reviewed in recent weeks and increased in line with the dependency needs of people and occupancy levels. The numbers of care staff on the day shifts had been increased to seven and the numbers of night care staff to four. The regional operations manager explained there was no formal staffing tool linked to people's dependency levels to help calculate the staffing numbers required and no regular set timescales for reviewing the staffing levels. This meant there was no effective system maintained for determining the numbers of staff required to safely meet people's needs. Records showed 30 staff had left the service since April 2015 (a number of nursing staff had left or been made redundant following the change in registration) and recruitment was on-going. People we spoke with told us there had been a lot of staff changes at the service and felt it had affected the continuity of their care.

We reviewed the staff rotas which showed regular shortfalls of staff. For example, from 1 February to 22 February 2016 we found the service worked short of staff on seven occasions. The rota demonstrated that

agency staff and bank staff from other services in the organisation were used on a regular basis. However, the support manager confirmed there had been high levels of sickness absence, for example the staffing rota for the week of the inspection visit showed six different members of care staff had taken sick leave.

The regional operations manager told us the domestic hours had recently been reviewed and increased but this increase in hours was not yet in place. They also told us the domestic worker on duty had worked 17 consecutive days due to the other domestic worker taking annual leave and they had worked the majority of time on their own. Given the large size of the facilities at the service, the recent provision of domestic support was inadequate.

Not ensuring there was sufficient staff on duty at all times was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We are considering our regulatory response and will report on it in due course.

Staff training records showed that 27 out of the 47 staff working in the service had not completed training in safeguarding people from abuse and only one of the senior care workers had completed this training. None of the staff had completed the training course on whistleblowing procedures. In discussions, we found care workers demonstrated a good knowledge of the types of abuse but two were not clear about reporting to external agencies. In January 2016, concerns about a member of staff's moving and handling practice and attitude towards a person who used the service had been reported by a member of staff directly to the person's relative which showed that staff were not following appropriate reporting procedures.

Prior to the inspection, North Lincolnshire adult safeguarding team had informed us there had been a high number of safeguarding concerns raised since November 2015. They had directed the acting manager to complete a number of the investigations into concerns raised and requested information to support their investigations. The safeguarding team reported to us they had concerns about the length of time the investigations were taking to conclude and the poor response to requests for information in relation to investigations they were managing. This meant systems and processes were not established and operated effectively to investigate safeguarding concerns. As a consequence to this, the safeguarding team attended the service during our inspection to gather information and have confirmed the investigations remain in progress.

When safeguarding incidents occurred, we found staff had not always followed local safeguarding procedures and notified relevant agencies such as the local authority safeguarding team and the Care Quality Commission (CQC). For example, a serious medication error was not reported to CQC. Another incident where a person had been found on the main road by a passing motorist was not reported to the local safeguarding team or CQC. Failure to investigate incidents puts people at continued risk of possible harm.

Failure to report and investigate safeguarding issues meant there was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We are considering our regulatory response and will report on it in due course.

The registered provider had not carried out full employment checks before staff started work in the service. We looked at the personnel records for four members of staff. The recruitment information held on file was inconsistent for three of the staff, which meant recruitment processes were not robust.

A Disclosure and Barring Service (DBS) check is required before a newly recruited member of staff starts working at a care home. The DBS has replaced the Criminal Records Bureau (CRB) and Independent

Safeguarding Authority (ISA) checks. The DBS helps employers make safer recruitment decisions and prevents unsuitable people from working with vulnerable groups. We were unable to determine if a DBS check had been completed for one member of staff as there was nothing on file in relation to the DBS. This member of staff's file contained an application form and interview records but no proof of identity records and only one reference. We observed shortfalls in two other personnel files which didn't contain applications forms. This meant gaps in the worker's employment history could not be checked out and other key information to support the recruitment process was not in place. One of these personnel files also contained only one reference; this meant information about the worker's previous employment conduct and practice was not in place.

Not having a robust recruitment system was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We are considering our regulatory response and will report on it in due course.

We reviewed the medication management system and found medicines were not managed safely. The report of the audit undertaken by the supplying pharmacy on 14 January 2016 showed numerous shortfalls with the management of medicines and findings from our inspection showed many of these had not been addressed. For example, we found controlled medicine had not been returned to the pharmacy promptly after it had been discontinued and staff had not recorded dates of opening on medicines which have limited life once opened. We also found 23 out of 31 medication administration records (MARs) checked were not completed properly. We checked the medicines dosage systems with the MARs for four persons and found the medicine was not in the dosage system which may have indicated the medicine had been administered but staff had not recorded this.

We found photographs were not in the medicines file for each service user to support safe identification. There was a lack of information to guide staff about how to safely administer 'as required' (PRN) medicines. The recording of whether one or two tablets were given when variable doses of pain relief had been prescribed was not always documented. There were no protocols in place to support the use of PRN psychotropic medicines. There was no consistent completion of the reverse side of the MARs which meant the recording of reasons for PRN administration were not always documented.

Checks of the MARs for 31 people also showed medicines had not been given to a total of five persons on different dates as they were not available. This shows poor stock control and the failure to provide medication as prescribed.

Two people had not received a controlled drug in the form of pain relief patches at the correct intervals during December 2015 and January 2016. They should have been applied every 72 hours but instead had been applied inconsistently with one person having a gap of 14 days between administration. The records showed the person became drowsy, unwell, required GP assessment following the administration of the medicine and was cared for in bed for over a week. The administration of the medicine after such a time lapse was not an appropriate decision for staff to make without guidance from the person's GP. This demonstrated that people's health and safety was placed at risk by staff who adopted inappropriate and unsafe medicine management without seeking appropriate medical advice. The community nursing staff had raised safeguarding concerns about this incident and they also reported concerns on 2 February 2016 in relation to staff not informing them of a person's discharge from hospital, which meant there was a delay in their insulin administration to support the safe management of their diabetes.

When we observed medicine administration, we noted the senior care worker assisted a person to take their medicines and they left the medicines trolley open and unlocked in the adjacent sitting room area; they

took five minutes to return to the trolley. We also observed they administered the person's tablets mixed up in a soluble medicine. This practice could be considered covert administration. When we asked another senior care worker how they administered the person's medicines they said they gave them in their porridge. There were no records in the care file, such as discussions with and consent from the person, a capacity assessment or best interest's decision to support administration of medicines with food. Nor was there any evidence the staff had considered any contra-indications such as incompatibility, absorption or interactions if the medicine was administered with other medicine or food.

Checks of training records and discussions with senior care staff and the regional operations manager showed the staff responsible for medicine administration had completed a range of training courses and undergone assessments of their competency. Despite this, the findings showed continued shortfalls with medicines management.

Not ensuring the proper and safe management of medicines so that people received them as prescribed is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We are considering our regulatory response and will report on it in due course.

We saw that records were in place to demonstrate that regular checks of the building and equipment took place to help keep people safe. This included electrical wiring, fire safety equipment, gas appliances and the passenger lift. However, we identified concerns with the management of risk to protect people's safety. We found there was a safety gate fitted at the bottom of each stairway and two people's rooms contained stone mantelpieces and hearths. These areas had not been assessed for the risk to people's safety. There was no lock fitted to the laundry door to ensure people's safety even though on 9 January 2016 a person had been found in this room having fallen on the floor. Adjacent to the laundry, we found an external door was locked, although this was not the designated fire escape we were unsure if the locked external door compromised the safety of people who used the service and staff. This new door lock was not detailed within the fire risk assessment and following the inspection the regional operations manager arranged for the lock on the door to be removed and confirmed they had requested a visit from the fire safety officer.

There was a system in place to complete individual risk assessments for people who used the service in relation to their support and care, but these had not always been implemented, completed accurately or reviewed and amended in response to their needs. For example, one person was found outside the building on a number of occasions in November 2015, including on the main road. They had also been found in the laundry and on the first floor of the service on 7 February 2016 yet a risk assessment to direct staff to monitor the person's whereabouts was not put in place until 15 February 2016. Three other people's risk assessments for falls had not been reviewed appropriately to reflect an accurate risk status although they had sustained significant injuries such as a fracture and lacerations. An assessment for the use of bed rails for one person had been completed on the 16 February 2016. This assessment indicated that bed rails should not be used as there was a risk of falling as the person could climb over the rail. An accident record dated 3 January 2016 detailed the person had been found hanging over the side of the bed. However, on the three days of the inspection, we observed the person was cared for in bed and there were bed rails in use at all times. This was contradictory and staff could not explain the rationale behind this decision or why there had been changes.

Not assessing, updating and managing risk appropriately meant this was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We are considering our regulatory response and will report on it in due course.

There was an infection control policy and procedure and contracts in place for domestic and clinical waste

disposal. Records showed some staff had received training on infection prevention and control. We completed a check of the environment to ensure it was clean and safe for people who used the service and found areas were not clean such as the laundry, some beds and furniture. We found there was an unpleasant odour in some parts of the service such as the corridors on Grove Court and Pine Tree Court and one person's bedroom. We also found some carpets were heavily stained in both communal and bedroom areas. The acting manager confirmed some new carpets had been ordered and were due to be fitted the following week.Cleaning records showed daily tasks were completed, however there were gaps with the completion of weekly tasks. We were shown a new cleaning checklist which had been put in place for the night staff, but we found this had not been completed appropriately.

We noted equipment such as a bed rail protector and pressure relief cushion had splits in the material covers which meant they couldn't be cleaned effectively. Two bed frames were split and paint had worn off two mobile hoists revealing the metal underneath which also meant they could not be cleaned effectively. In a ground floor toilet in Pine Tree Court, there was a gap between the linoleum flooring around the edge of the toilet base where the concrete floor was exposed. Tiling in toilets and sluices had fallen off the walls and left exposed plaster and emulsion, which made these areas difficult to keep clean. We also found items of equipment such as a bed wedge, mobile hoists and a bath hoist were dirty. Our observations demonstrated that the registered provider was not taking adequate steps to protect vulnerable people from the risks associated with an unclean environment.

Not ensuring adequate standards of hygiene meant this was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We are considering our regulatory response and will report on it in due course.

Inadequate

Is the service effective?

Our findings

People who used the service told us they liked the meals provided and they had sufficient to eat and drink. Comments included, "The main meals have improved a lot with the new chefs here now. They could give us more choice at tea time though, kippers and things like that" and "Yes, I enjoy all the meals, very tasty and a good choice."

People also confirmed staff called their GPs when they were unwell. They said, "Yes, they always get the doctor if needed" and a relative told us, "Staff recently contacted the GP for [relative] because they suspected a chest infection."

We checked people were supported to maintain good health, had access to healthcare services and received on-going healthcare support. Prior to the inspection, safeguarding concerns had been raised earlier in the month by community nursing staff about the standards of care provided to their patients. This was due to the length of time they had recently spent at the service providing treatment for skin tears and pressure damage. Concerns had also been raised in relation to the delay in referring one person to the community health team following an adverse reaction to their morphine medicine and the subsequent decline in their health. Records showed the staff had initially contacted the person's GP but when they remained confined to bed, staff had not contacted the community nursing staff until pressure damage was evident.

We saw records were kept of appointments and visits made by doctors, district nurses, community psychiatric nurses, optician, occupational therapists, dieticians and chiropodists. However, changes made by some health care professionals were not always followed up on or easily recognised within people's care records in terms of changes to care and treatment. For example, in one person's records the community nursing records dated 25 January 2016 detailed hourly repositioning support was required and they had ordered a high risk pressure relieving mattress and cushion. The person's care plan was not updated to reflect this information. When we checked the repositioning records they showed gaps of up to six hours with care support.

Not ensuring people's health care needs were met in an effective way was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and we are considering our regulatory response and will report on it in due course.

We spoke with visiting health care professionals during the inspection who confirmed that a member of staff was now allocated for the duration of their visit to the service to provide assistance and ensure any advice, guidance and treatment they provided was clearly recorded. They considered communication was improving. The support manager confirmed that supplementary records and progress notes were now held in people's rooms to prompt staff to complete them at the point of care delivery. A new staff office had been created and staff were provided with centralised records and new communication books to assist them to carry out their work.

We found there were gaps in the staff training and supervision programmes. The staff training matrix record showed some staff had not received training in areas which the registered provider considered essential such as safeguarding, infection prevention and control, food hygiene, dementia, Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS), fire safety, health and safety and first aid. The records showed that although some staff had completed the training, many of the courses were now out of date and staff required refresher sessions. When we discussed the gaps in the staff training programme with the acting manager they were unable to account for this and could provide no information or assurance that the outstanding training was scheduled.

Staff training files had not been appropriately maintained. We checked four staff files and found these did not contain training certificates for all the courses the training matrix detailed staff had attended. For example, the training file for one member of staff contained the induction record and certificate for basic life support from 14 December 2015 but did not contain the infection prevention and control and moving/ handling certificates for the training they attended on 1 December 2015. When we asked the acting manager for the training certificates she could not provide these.

There was no evidence staff had completed training to meet the individual needs of people who used the service in areas such as: nutrition, catheter care, Diabetes, dignity awareness and end of life care although the regional operations manager confirmed these courses were available. Following the concerns with increases in incidence of pressure damage in recent months, the community nurse had provided pressure damage prevention training for staff. Two sessions had been provided and further sessions had been arranged.

The regional operations manager confirmed seven staff currently had responsibilities for administering medicines. Training records showed they had completed two training sessions since September 2015 and at least three assessments of their competence in administration practices. Senior care staff had also received individual supervision and attended meetings outlining expectations of their role. However, there were continued issues with all aspects of medicines management found during recent external and internal audits and during our inspection. Following a serious medication error in January 2016 which involved all senior staff, we found no evidence they had undergone further competency assessments of their practice.

Checks of staff supervision and appraisal records showed the majority of staff had not had opportunities to discuss their work role and responsibilities for some time. The regional operations manager confirmed all the senior care staff had received supervision in January 2016 and records confirmed this. There was no supervision programme in place and we found no evidence in the staff files we checked that staff had received an appraisal since working at the service.

The findings above show that not all staff were provided with appropriate support and training which was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and we are considering our regulatory response and will report on it in due course.

We checked people's needs were being met by the adaptation, design and decoration of the service. There was some limited signage in Grove Court to help people living with dementia to find their way round, such as pictorial and written aids. The corridor linking the two units had been decorated in a street theme with faux brick wallpaper, sweet shop, post box and room doors painted in the style of a front door. There were minimal adaptations to meet people's dementia needs in Pine Tree Court and in this unit we also found the decoration in some communal rooms, corridors and bedrooms was tired and in need of refreshing. In some corridor areas we found paint and wall paper peeling off the walls and in one place an area of plaster had come away exposing brickwork on the wall. Paintwork on doors and skirting boards was scuffed and

marked which showed worn and damaged woodwork in places. In the linen cupboards and in people's rooms, we found a large number of frayed and worn towels. Outside, the exterior woodwork on the window frames, doors, porch and fascia boards was very worn with peeling paint and bare and damaged wood showing through. The acting manager confirmed the medicines room had been refitted, new flooring was due to be fitted in the dining room the following week and improvements had been made to the information technology systems at the service. However, there was minimal evidence of any redecoration in the last 12 months and there was no annual renewal programme in place which had been agreed and approved by the registered provider.

The findings above show the premises were not properly maintained which is a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and we are considering our regulatory response and will report on it in due course.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

From discussions with staff and records seen, we found the principles of MCA had not been applied consistently and lawfully. Although some people's care records contained completed capacity assessments, these did not clearly outline what decisions they specifically related to or why they had been completed. We found care files contained consent records such as care plan agreements and consent to the use of photographs, however the majority had not been completed. Checks on care files showed decisions had been made in relation to people's end of life choices but there were no capacity assessments or best interest records in place to support these decisions. Three of the DNACPR [do not attempt cardiopulmonary resuscitation] records indicated the person did not have capacity to make the decision. There was no demonstration of MCA assessments in these people's files.

Restrictive practices were observed, such as the use of bed rails, Kirton chairs for two people and the use of sensor alarms on floor mats and seat pads. When we checked the person's care records, we found there were no capacity assessment records to show this area of need had been assessed. There were no records of any best interest meetings to support an agreed approach to meet the person's needs in a least restrictive way. In discussions, a member of staff told us they administered one person's medication in their food; they considered the person did not have capacity to consent to this practice but we found associated capacity assessment records and best interest decision records were not in place. The registered provider did not have suitable arrangements in place for people to consent to their care or follow legal requirements when people could not give their consent.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care services are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. Records showed two authorisations had been applied for and granted and there were no specific conditions applied to the authorisations. One further application had been submitted and was awaiting review. Checks on the care records for the person who had left the building on four occasions in November 2015 showed that neither an urgent or standard DoLs application had been made. We found restrictions on people's movement such as access control on the front doors and continuous supervision was in place but the service had not always assessed people's capacity and made appropriate DoLS applications in line with the

requirements of the MCA. In discussions with regional operations manager and support manager, they told us that due to the complexity of needs of many of the people at the service they would expect DoLS applications should have been submitted for the majority of people at Haverholme House.

The evidence above established a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in respect of consent to care and treatment. A breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 was also demonstrated in respect of shortfalls around practices at Haverholme, which failed to demonstrate the deprivation of liberty safeguards being implemented for service users who lacked capacity, but who had on-going control and restrictions placed upon them. Regulation 13, Safeguarding Service Users from abuse, is the regulation that expressly deals with the deprivation of liberty safeguards under the Mental Capacity Act 2005, their implementation and the restrictions that a Service provider can lawfully place on a service user's liberty of movement and choices, where service users are controlled or restricted, but lack capacity to consent to those restrictions and controls.

We saw menus provided people with a range of nutritious meals, which were posted on notice boards. We observed four meal times during our inspection. The meals looked appetising and well-presented. However, we found meal time routines were very busy and more staff were needed to improve the organisation of meal service and support a better experience for people. For example, we found a high number of people required support with eating in their rooms which meant there were less staff to support people in the two dining areas. On occasions we observed there was only one member of staff to support up to twelve people in the dining room on Grove Court, many of whom required regular assistance with prompting, encouragement and eating their meals.

We observed the cook spent time speaking to each person about their meal choices for the day. Although the cook had a good knowledge about specialist diets and could give an account of how they provided fortified diets, they had limited knowledge of people's individual's nutritional needs. We found there were no records of people's individual nutritional needs and preferences held in the kitchen for reference and some people's care records also had limited information about this area of need and choice.

We saw people being offered drinks and snacks regularly during the day. A good range of high calorie savoury and sweet snacks were available including full fat yoghurts and mousses for people who required a soft diet.

Requires Improvement

Is the service caring?

Our findings

People who used the service told us the staff were kind and caring but they described staff as being "very busy" all the time. Comments included, "They are caring and do their best under the circumstances but they don't have time to spend with us", "The staff are always helpful and kind, we have to wait a bit sometimes for assistance but we get well looked after", "They put their head round the door when they are passing but they don't have time to stop and have a proper chat" and "They will always come if you need anything. I've missed a few showers as they've been busy but nothing to worry about."

We asked people if staff respected them and maintained their dignity. Comments included, "The staff are very nice, I'm happy here" and "Staff are always polite and knock on the door before they come in, they are good like that." Relatives told us, "They seem really caring to my mother" and "Yes, they are kind and caring, sometimes we need to remind them about the little things though."

The regional operations manager told us there were no restrictions placed on visiting times and families could visit anytime. Relatives we spoke with confirmed this and told us staff were welcoming. However, some mentioned the delays with staff answering the door and some staff not having a 'key fob' to let them in, which meant they were waiting out in the cold weather. The regional operations manager confirmed all staff had now been issued with the 'key fobs' and reminded about responding promptly to the door bells.

People told us they had not been asked their preferred gender of staff for providing personal care. A person said, "No, I've not been asked about that. I don't mind really but I suppose we could choose if we wanted to." We did not see in the care records we looked at that people's preferred gender of staff to provide personal care was recorded. A member of staff told us there were four male carers employed at the home and they provided care to females but usually with a female carer present.

In the corridor area on Grove Court, there was a 'dignity tree' on the wall. This was to enable people who used the service, their relatives and staff to write down their thoughts about what dignity means to them and for their views and wishes to be displayed to remind staff and each other what was important to everyone as an individual. It was unclear if these were checked to see if it was possible to address some of them or if new residents had the opportunity to contribute. There was information on notice boards about the organisation's new dignity initiatives. When we spoke with the regional operations manager about these, they confirmed they had been rolled out at the service, although two of the staff we spoke with told us they were not aware of these.

We saw at peak times of the day staff were very busy and they had to ask people to wait for assistance, telling them they would come back to attend to them as soon as possible. This caused some people to be anxious. We had to request assistance for people on three occasions; one person had become upset waiting for a member of staff to assist them with toileting, another person required assistance with dressing and a third required their clothing adjusting to ensure their dignity was protected. We also noted at times there were delays with staff transferring people from wheelchairs into comfortable armchairs, for example after their meals or when they were assisted into the lounge.

We observed some caring interactions between some staff and people who used the service, particularly during the medicines round or when they were supported to transfer using the hoist; staff spoke clearly and patiently and made people feel comfortable. Positive interactions were also noted during the lunch period, once the meal had been served. However, unless staff were prompted or responding to people's physical needs, there was very little general interaction. For example, there were six people with complex needs who spent the majority of time in bed. Apart from the times staff spent providing personal care and assistance with feeding, we observed these people spent long periods of time alone and without any interaction from staff members. Some people spent most of their time asleep or withdrawn. When people were awake we observed there was no other stimulation, such as a television or radio operating in their room, magazines or books.

There were no locks on any person's room doors to support their privacy and in Pine Tree Court we found a number of older style swing doors in place with no closure devices fitted. The regional operations manager confirmed these issues had been identified to the estates manager and would be addressed within the renewal programme.

We saw a range of information was provided in the entrance hall and on notice boards in corridors for people who used the service and visitors. This included information on how to keep safe, advocacy, activities and how to make a complaint.

People had chosen what they wanted to bring into the service to furnish their bedrooms. They had brought their ornaments and photographs of family and friends or other pictures for their walls. This personalised their space and supported people to orientate themselves. We observed staff kept people's rooms tidy and respected their possessions.

The regional operations manager told us no one who lived in the home had an advocate at the time of the inspection. However, they confirmed they would assist people to access an independent advocacy service if required.

Inadequate

Is the service responsive?

Our findings

We asked people about activities in the home. People gave different accounts of their experience. One person told us they loved the bingo sessions and the singers that visited. Another person told us they spent large amounts of time in their bedroom looking at the birds in the garden and watching TV as they preferred their own company. They said the activity co-ordinator was nice and friendly and they occasionally joined in with activities.

People who used the service told us they would be able to complain if they needed to. Comments included, "I've complained about the meals on a regular basis, they usually improve for a while" and "I haven't had to complain but would speak up if I had to." Relatives spoken with said, "They have dealt with a couple of things I've mentioned, but it wasn't anything very serious" and "I've recently made a complaint and the manager hasn't dealt with it so I've asked for it to be escalated up to the owner."

We found concerns in the way people's care and welfare was planned and delivered. Also assessments did not include all the relevant information and did not reflect people's up to date care needs. There was little evidence of a person-centred approach to care and support to people.

The majority of people who used the service had dementia related needs. Life biographies were not completed for all people. Although most of the files checked contained the record entitled, 'This is Me', which gave a summary of the person's background, interests and current care needs, we found the majority were blank or poorly completed. This meant staff may not have a sense of the identity of the people they supported which could affect the standard of person-centred care provided, daily living choices for the individual and communication.

There was no evidence of any involvement from the person who used the service or their relative in the design of the care plans we looked at. Three people we spoke with confirmed they had not been involved in the development of their care plans; they were aware staff kept such records but they had not seen them. Two relatives we spoke with told us they had not been consulted about their family member's care plan. People's individual preferences for how they wished their care to be delivered were not recorded, apart from very basic information.

We saw daily recording of care provided to people focused on tasks such as giving people medicines, meals and personal care. This kind of reporting did not focus staff attention on person-centred care such as how the person experienced their day, whether they enjoyed their meals, how they spent their time, whether they were happy or how their mood affected them.

We reviewed one person's care file and found the information in this document was extremely limited. No assessment documents were contained in the record. This person had been admitted to the service for regular respite care support in recent months. An accident record detailed they had experienced a fall on a previous admission. There were no mobility or falls risk assessments completed. There were no care plans to direct staff on any support the person would require to meet their care needs in relation to: mobility,

medication, nutrition, personal care or activities of daily living.

Care plans did not provide sufficient detail and directions for staff especially around areas of care such as: catheter management, mobility, prevention of pressure damage, prevention of falls, personal care and nutrition. For example, one person's personal care plan was very basic and detailed, 'staff must support with minimal of 2 carers; staff to remain with service user throughout and staff must ensure personal hygiene remains at a high standard'. This did not provide sufficient clear guidance in how to support the person's personal care needs and preferences. Another person had a catheter in situ; the care plan directed staff to empty the catheter bag when requested and ensure the catheter was draining. There was no guidance about personal hygiene, bag and tubing positioning, day and night care, monitoring of urine and monitoring of fluid intake.

We also saw many examples where areas of need had not been assessed and planned for. For example, one person had fallen and sustained a fracture of a bone in their leg. We found the mobility care plan had not been updated to reflect they could no longer weight bear on the injured leg and care plans were not put in place to direct staff with the support this person required in relation to their pain or care of the cast. Records showed the person had fallen again whilst the plaster cast was in place. Another person had fallen and sustained large lacerations to their forehead which had required suturing at hospital. We found care plans had not been put in place to direct staff on monitoring for signs of further head injury, pain management or wound care.

We found people's needs in relation to prevention of pressure damage were poorly assessed, planned and reviewed. People did not receive consistent support in relation to prevention of pressure damage. For example, one person's assessment of their risk of sustaining pressure damage was recorded as 15 and 17 (high risk) in January and February 2016 but we know from our review of their care records, that their risk assessment was inaccurate and should have reflected risk scores exceeding 20 (very high risk). There was no care plan in place to support staff to care for this person's risk of developing a pressure ulcer. Multidisciplinary and daily records detailed skin damage to the person's sacrum and heels in November 2015 and February 2016 and discoloration to their toes in December 2015 which required intervention and treatment by community nursing staff.

We found the service took ineffective action in relation to weight loss. The service used the Malnutrition Universal Screening Tool (MUST) and an organisational nutritional risk tool to identify those at risk of malnutrition. However, when risks and concerns were identified we found inconsistent decisions made with regards to intervention such as the promotion of weight gain strategies and liaising with local health professionals. People's weights were measured infrequently even when weight loss had been identified. For example, one person's records showed they last received support from the dietician in September 2015 when their weight was stable and their risk scores were low. The person's records showed their weight was 47 kgs in August 2015 and 39.70kgs in January 2016 and there were no further recordings. There were no records to demonstrate a recent referral had been made the person's GP or to the community dietician for review. The person's care plans and assessments had not been reviewed and updated to provide clear guidance for staff on meeting their current nutritional needs.

Communication was not good in ensuring all care staff working in the service had enough information to respond to people's changing needs. Staff told us that the care plans were not routinely looked at as a means of gathering information to deliver care. Although we saw recent improvements to the quality of handover reports, staff mainly relied on transferring information verbally between each other which meant there was a risk that important care would be missed or information not acted on in a timely manner. This was of particular concern as there was not always enough staff available at the service coupled with a

reliance on agency workers and a high turnover of staff. These factors placed people at risk of inconsistent care or not receiving the care and support they need. The regional operations manager confirmed they had recently introduced new handover records to support more effective communication.

There was no evidence to show that charts used to monitor people's care had been reviewed at regular intervals to ensure any necessary action required was reflected in care plans. Where food and fluid intake was being documented this was not being evaluated over a period of time to establish whether people were getting the required nutrition and fluids. Similarly repositioning records weren't reviewed to ensure the frequency of support was effectively meeting the person's needs. Daily personal care records showed they were either not completed fully or indicated people were not receiving personal care such as a wash, shower or bath in line with their care plan.

We found people's social needs were not being met. At the time of the inspection the activity co-ordinator was on leave and we saw minimal activities taking place. We observed there was a lack of stimulation for people, especially those people living with dementia; they were sat with nothing to do for long periods of time, sleeping or disengaged. Some people wandered the corridors going into other people's bedrooms. Care plans held limited information about people's social requirements and activities they participated in. For example one person's activity record showed 'observing wildlife' and 'dolly' recorded on 16 February 2016 were the only entries.

The shortfalls in assessing needs and planning care meant there had been a breach in Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and we are considering our regulatory response and will report on it in due course.

There was a complaints procedure on display in the entrance hall. The complaints policy and procedure informed people of who to speak with if they had any concerns and timescales for addressing complaints and responding to people. We reviewed the complaints file and found five complaints had been received in May, July and October 2015. Records showed only three complaints had been investigated. There were no records of any acknowledgement or any records of a formal response sent to the complainants.

Prior to the inspection, we were provided with copies of email correspondence between a complainant and the acting manager of the service. The complainant had raised a number of concerns about the quality and safety of the care provided to their family member. The acting manager had confirmed on two occasions via email that they would provide a written response, however this was not provided. When we checked the complaints file we established that this complaint had not been recorded and therefore it could not be confirmed that this matter had been investigated. This demonstrated that people's concerns were not investigated and responded to appropriately.

Not ensuring complaints were managed appropriately was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

At the start of the inspection, we were informed that the registered provider had taken the decision to employ a support manager to provide support to the acting manager and help them to develop their performance to the required standard to enable them to continue to run the service. During the first two days of the inspection, we experienced difficulties in accessing information from the acting manager; there were delays in receiving information requested and information not being available or provided. The office was in disarray and disorganised. Many of the files seen had not been properly maintained, information was not easy to access and on numerous occasions we were told the records requested could not be found. On the second day, we were informed the acting manager had resigned and left the service. The regional operations manager confirmed that the support manager would be taking over day-to-day management of the service with assistance from the senior management team.

During this inspection, we found the service was not well-managed. Although there was evidence of regular visits to the service by the regional operations manager, quality manager and the CEO, we found the acting manager had not received adequate formal support or supervision from the registered provider to ensure they had the skills and experience to manage the service. There were no records of regular monthly management meetings to show how progress had been maintained and goals had been set. We found staff lacked leadership and oversight from the acting manager. These points meant that risk was not managed effectively and important care issues were not followed up; this had impacted on the safety, health and welfare of people who used the service.

The regional operations manager confirmed the registered provider had taken the decision to change the registration so they no longer provided nursing care at the service. This was due in the main to on-going difficulties in recruiting qualified staff and providing sufficient qualified staff to cover all the shifts. They confirmed people with nursing needs had been transferred to alternative placements in October 2015. Checks on our records identified that an application to formally remove the relevant regulated activities from the service registration had not yet been submitted correctly and accepted. The regional operations manager confirmed they would re-submit a new application.

The regional operations manager described the long- standing conflict and problems between the management and some members of staff at Haverholme House. She confirmed there had been an increase in whistleblowing concerns in recent months and the acting manager was struggling to maintain control of the situation. This had been a factor in the appointment of the support manager. During the inspection staff told us they were unclear of their roles and responsibilities. One member of staff said they felt they lacked direction. Another member of staff said there was conflict between some staff and this was not managed appropriately. Staff told us morale was low. A member of staff also expressed dissatisfaction in the shift patterns and arrangements for annual leave.

We found the quality monitoring programme in place at the service was ineffective; there was little evidence of any detailed audit tools used. For example, no records were available to support any specific audits of care records, activities, standards of hygiene, décor/ maintenance, safeguarding incidents, weights,

complaints and concerns, staff training, supervision and appraisal meetings. The regional operations manager informed us that audits of infection prevention and control had been completed but they weren't available. During the inspection, we found significant shortfalls in all these areas.

An audit programme linked to the KLOEs (Key Lines of Enquiry are a set of question formats the Care Quality Commission (CQC) has developed to focus inspections and judgements on the fundamental standards) had been put in place in June 2015. The regional operations manager informed us that each month a different audit should be completed on a rolling programme. We found audits had been completed in June, July, November, December 2015 and February 2016. Where shortfalls had been identified, there was little evidence of any clear action plans developed to address these and support the necessary improvement work. For example, in the audit dated 14 November 2015, to the question, 'Are resident's files neat, tidy, in good working order and up to date?' The acting manager had recorded, 'No- full audit and review needed'. There was no information about the number of records, timescales or persons responsible to undertake the improvement work. There was no evidence that any care audits had taken place. This meant there was no effective system in place to assess, monitor and improve the quality and safety of the service.

The acting manager had completed a Service Improvement Plan (not dated) which covered 18 areas of improvement. These included: marketing the service; care plans; medication storage, training, menus and catering, cleaning; quality assurance, maintenance, meetings and communication, KLOE audits; manager's office; reception area; supplementary care records; fridge temperatures; Mental Capacity Act 2005 and Deprivation of Liberty Safeguards; redecoration and personnel files. However, we found the improvement plan had not been properly reviewed, updated and maintained. The majority of areas of improvement had no timescales recorded for completion and the acting manager had recorded 'on-going'. There was little evidence of progress for completion with the majority of areas on the improvement plan. This meant there was no effective system in place to assess, monitor and improve the quality and safety of the service.

The Provider Assurance Team (PAT) at North Lincolnshire Council, completed an assessment on 19 October 2015 where many shortfalls in the standards of service provided were identified. An action plan was produced, dated 21 October 2015, to address improvements required in relation to nutrition, safeguarding, medicines, MCA and complaints. The PAT had completed a further monitoring and assessment visit on 7 December 2015 and due to concerns around the lack of improvements in the areas re-assessed, a meeting was requested and held with the regional operations manager and acting manager on 21 January 2016. Prior to the inspection, an officer from the PAT informed us they had completed a further assessment visit on 10 February 2016 and the necessary improvement work in relation to MCA had not been completed.

A comprehensive health and safety audit had been completed on 10 November 2015 by an external company. The findings were provided in a detailed health and safety action plan and showed urgent action was required in two areas: maintenance and inspection of gas systems (one of the boilers had been condemned and kitchen equipment not serviced since July 2014) and a thorough examination of the lift (not completed since January 2015 and should be 6 monthly). Records were in place to support these urgent actions had been completed. The report also detailed 22 areas where further action was required. The acting manager could provide no evidence that action had been taken to address these areas of concern and the timescales had now expired. Following the inspection the registered provider confirmed they had completed the improvements detailed on the action plan.

Risk had not been managed effectively in order to learn from incidents to prevent reoccurrence. This meant that one person continued to use a bed rail when it was unsafe for them and people continued to have falls without an accurate review of risk. Not all the incidents and accidents were recorded appropriately on the relevant forms. The incidents of falls were not fully analysed to identify trends or themes for individuals or

for the service as a whole in order to minimise risks and improve outcomes for people.

Regular audits had been carried out on the medicines systems by the service staff and by the supplying pharmacy. Audits showed significant shortfalls in areas such as recording and administration, however action plans had not been put in place to address these and there was little evidence of any consistent improvements. A meeting was held with senior staff in January 2016 because medicine audits were still showing shortfalls indicating improvements were not being achieved. However, further actions were not identified to ensure improvements. During this inspection, we found there were recording issues with 23 of the 31 medication administration records that we looked at. This meant there was no effective system in place to protect people from the unsafe use and management of medicines.

Not having a robust quality monitoring system meant there has been a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We are considering our regulatory response and will report on it in due course.

We found the acting manager was not fully aware of their responsibilities in notifying the Care Quality Commission about incidents that affected the safety and welfare of people who used the service. When we checked our records, we found there were several serious injuries such as skin lacerations and fractures, an incident where a person was found on the main road by a passing motorist and a serious medication error which had not been sent to us as notifications.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009 Notification of other incidents. We are considering our regulatory response and will report on it in due course.