Hadleigh Care Limited

Hadleigh House Residential Home

Inspection report

350 Pelham Road
Immingham
North East Lincolnshire
DN40 1PU
Tel: 014 6957 2514

Date of inspection visit: 18,19, 22 & 24 June 2015
Date of publication: 14/08/2015

Ratings

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

Overall summary

We undertook this unannounced comprehensive inspection on the 18, 19, 22 and 24 June 2015. At the last inspection on 12 and 13 September 2013 we found the registered provider was compliant in the areas we assessed.

Hadleigh House Residential Home provided personal care to a maximum of 35 older people who had a range of physical health care needs, some of whom were living with dementia. On the first day of the inspection visit there were 25 people using the service. Hadleigh House Residential Home was situated in a residential area not far from the centre of Immingham.

There was a registered manager for Hadleigh House Residential Home, however they gave notice and resigned on the first day of the inspection. A registered manager is a person who has registered with the Care Quality Commission [CQC] to manage the service. Like

Summary of findings

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 the registered provider was in serious breach of ten regulations of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014. These were in relation to person centered care, dignity and respect, safe care, safeguarding people from abuse, safety and suitability of the premises, cleanliness and infection control, staffing levels, supporting workers, obtaining consent and working within the requirements of the Mental Capacity Act 2005, assessing and monitoring the quality of service provision, fitness of the director and fitness of the registered manager. We also found a breach of Regulation 18 of the Care Quality Commission [Registration] Regulations 2009 for non-notification of incidents. The majority of these breaches were assessed by CQC as extreme, as the seriousness of the concerns placed a significant risk on the lives, health and well-being of the people living in the home.

There had been a failure to protect people from harm and abuse and to recognise and report when people had been put at risk or had been subject to harmful situations. This meant the local safeguarding policies and procedures had not been followed in these instances and also meant there was a delay in the safeguarding team having the opportunity to comment on the incidents, provide advice or take any action.

The staff did not have the knowledge and skills to support people or follow legal processes to make decisions in their best interests. People living at the home 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].

Records showed staff had been recruited safely but there were not enough staff available to meet the needs or maintain the safety of the people living at the home. Due to the serious concerns about the shortages of senior care staff identified during the inspection, the assistant director of North East Lincolnshire Clinical Commissioning Group arranged for additional staff from an external source to work at the service to oversee and ensure people's safety and welfare was maintained.

Routines were busy, disorganised and care support rushed. Although staff were kind and willing they had a task based approach to care and did not always promote and protect people's safety and dignity.

The environment at Hadleigh House was poorly maintained and unsafe. Fire safety systems were not properly maintained or followed. There had been limited adaptations to support people living with dementia. The premises were also very unclean and placed people at risk from infection.

There was a lack of regard for people's social and recreational needs and a lack of opportunity to engage in activities, entertainment or visits into the community. People were sitting in the lounges or their bedroom with no meaningful activity or positive interaction taking place.

We found people's preferences, choices, likes and dislikes were not explored with them. This meant the service could not deliver individualised care and support that was in line with what people wanted and needed.

Care plans were poorly written and did not describe people's needs properly. People's changing healthcare needs were not known and understood. People were at risk of harm because the service failed to respond promptly and appropriately to new care needs. People did not have risk assessments in place for specific concerns. Incidents and accidents had not been analysed to help find ways to reduce them.

Whilst people told us they enjoyed the meals served to them at Hadleigh House the home did not have a robust way of monitoring people's nutritional and fluid intake. This meant they could not evidence that some people were receiving sufficient food and drink to maintain their health and wellbeing. People had lost weight but this had not been recognised and followed up.

Overall, we found safe systems in place for obtaining, storing, administering and recording medicines. However, when medicine errors had taken place steps were not always put in place to minimise the risk of these errors occurring again in the future. Staff who had made the errors were not given additional training and assessed as being competent to administer medicines following the errors.

Summary of findings

The service was poorly led, with a lack of management support in the home. There were no effective systems or processes in the home to ensure that the service provided was safe, effective, caring, responsive or well led. The interim management team and registered provider were unable to demonstrate the skills, knowledge or ability to make the urgent changes that were required to make the service safe during the time period that the inspection took place.

CQC used it's urgent powers to apply to the Magistrates Court on 29 June 2015 and received a court order to cancel the registered provider's registration to carry out the regulated activity of accommodation for persons who require nursing or personal care at Hadleigh House Residential Home.

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?

Inadequate

The service was not safe.

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

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

The premises were dirty, mal odorous and unhygienic. Systems to protect people from the risk of infection were not effective.

The home did not have sufficient staff on duty to meet people's needs safely.

Is the service effective?

Inadequate

The service was not effective.

Suitable arrangements were not in place for people to consent to their care

or for staff to follow legal requirements when people could not give their consent. We found people were unlawfully restrained.

Systems were not in place to ensure people's changing healthcare needs were known and understood. There were delays in people receiving professional advice and treatment.

Staff had not received all the training, supervision and professional development to enable them to deliver care and treatment to people in the home safely and to an appropriate standard.

Is the service caring?

Inadequate

The service was not caring.

People were not supported to maintain their personal care in a dignified way that supported their well-being. Care mainly focused on getting the job done and did not take account of people's individual preferences and did not always respect their dignity.

Staff lacked the leadership they needed to support people appropriately with their mental health needs and to promote people's independence and self-worth.

Staff were not always attentive, especially when supporting people living with dementia and during mealtimes.

Is the service responsive?

Inadequate

The service was not responsive.

People were not receiving a person centred service. Their preferences and choices and their likes and dislikes were not explored with them.

People living in the home were not receiving care that met their individual needs.

Summary of findings

There were no activities to stimulate or encourage people to undertake meaningful activity.

Is the service well-led?

Inadequate

The service was not well led.

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

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

Recording did not evidence people's care needs were met.

Notifications had not been made to the Care Quality Commission for all safeguarding incidents.

Hadleigh House Residential Home

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 & 24 June 2015 and was unannounced. The inspection was completed by three adult social care inspectors, an inspection manager and an expert by experience.

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 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 safeguarding team and a contracts officer from North East Lincolnshire Clinical Commissioning Group [NELCCG] about their views of the service.

We used the Short Observational Framework for Inspection [SOFI]. SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We spoke with eleven 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 throughout the day including meal times. We spoke with two community nurses, two social workers and a community matron who visited the service during the inspection. We also spoke with a safeguarding officer and the assistant director of care and independence at NELCCG.

We spoke with the registered provider, registered manager, deputy manager, the administrator, cook, domestic, laundry assistant, senior care worker and four care workers.

We looked at eight 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 six 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 three staff recruitment files, the training record, the staff rotas, supervision records for staff, minutes of meetings with staff and people who used the service, safeguarding records, quality assurance audits, maintenance of equipment records, cleaning schedules and menus.

Inadequate

Is the service safe?

Our findings

Some relatives we spoke with told us they had concerns about safety at the home. They were concerned about unwitnessed falls and a faulty lock not being repaired. We also spoke with another relative who considered their family member was not protected from harm. However, people who used the service told us they felt safe; comments included, "Safe enough" and "Feel safe here." We received mixed comments about staffing levels. These included, "Sometimes waiting for a long time when I press the call bell, but sometimes a short time", "Occasionally at the weekend it's noticeable the numbers are low" and "The staff work exceptionally hard, they only have so much time to do things."

We were prompted to bring this inspection visit forward as a result of concerns raised by the number of recent and serious safeguarding allegations. These included: poor care of a person who demonstrated behaviour which challenged the service; concerns that the registered manager did not take action when issues were reported to them; a person who used the service leaving the home unnoticed and being found in the local town centre; another person letting themselves out of the dementia unit on the first floor and falling down a flight of stairs; four people found in wet and stained beds on the same day; a person found to have bruising and this same person found restrained in their chair.

The concerns were being investigated by the local safeguarding team or Humberside police. The allegation of neglect in relation to a person falling down a flight of stairs had been investigated and substantiated by the local safeguarding team as it was found the door lock was faulty and had been reported to senior staff, but no action had been taken to carry out the repairs to ensure people's safety.

We found the registered manager had failed to follow local safeguarding procedures in referring incidents of abuse appropriately. This had resulted in one member of staff using the whistle blowing procedures to ensure a serious concern was reported appropriately and investigated. This meant there was a delay in the safeguarding team having the opportunity to comment on the incidents, provide advice or take any action.

We also found the registered manager had not taken further action following the serious concerns raised to ensure people were properly protected from improper treatment, harm and abuse. There was no evidence the registered manager had directed staff on safe care practices in the delivery of personal care for two people who demonstrated behaviours which challenged the service.

Staff we interviewed were able to tell us about some possible signs of abuse. However, in practise, our observations found that they lacked insight into what constituted abuse and, in particular, there appeared to be a lack of understanding of institutional and physical abuse.

During the inspection we submitted two referrals to the local safeguarding team as we found records which indicated staff were unlawfully restraining people and causing harm.

These issues meant there was a breach of Regulation 13 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014. The home did not have adequate arrangements in place to protect people from harm or abuse.

We found people were at risk due to very poor standards in relation to cleanliness and hygiene which meant the infection prevention and control systems were not adequate to prevent the spread of infection. For example, communal areas and people's rooms were dirty and this included: flooring, walls, carpets, furniture and equipment. We found dried faecal matter on a toilet seat and a person's bedroom wall. We also found strong odours of stale urine in corridors and 13 bedrooms; strong stale odours in all lounge and dining areas; wheelchairs and carpets stained with food and other debris, a leaking toilet, a used incontinence pad left on a bedroom floor, a bed pan left under a person's bed and urinals were not cleaned after use and left in toilets.

The laundry room was cluttered and boxes of unlabelled clothing were stored on the floor which posed a risk of cross contamination. The laundry walls and flooring were not clean. The flooring had a large split which had been covered by a piece of dirty carpet. We found used clinical waste was not managed and disposed of effectively.

We found many pieces of furniture and equipment were worn or damaged and therefore could not be cleaned effectively. This included bed bases, arm chairs, a pressure

Is the service safe?

relieving cushion, crash mat and many pillows and duvets did not have protective covers. We concluded that the premises were unhygienic and systems and procedures were not being followed to provide a safe and clean environment.

We identified concerns about fire safety management; during the inspection we observed visitors entering and leaving the building without signing in the visitors book; doors were wedged open including fire doors; the fire escape was unstable and locking devices on fire doors and an external gate required repair. This meant that there was a risk that people's safety may not be fully protected if there was an emergency at the service. We referred these matters to the local fire authority.

Checks of the hot water temperatures had not been completed since April 2015 and records showed the hot water temperature for one bath recorded 45 deg C which exceeds the recommended temperature. In the bathroom we found staff recorded hot water temperatures and these showed they were always maintained at 37degC; however when we asked staff about this they couldn't confirm if the record was the temperature of the hot water coming out of the tap or of the filled bath. Records to support twice weekly flushing of the cold water systems in line with the system for legionella prevention had not been completed since 5 May 2015.

These issues meant there were breaches of Regulations 12 and 15 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014. The premises were poorly maintained, dirty and did not meet people's needs safely. Systems to support effective infection prevention and control were not safe.

We found poor systems in place to manage and prevent the risk of harm to people. We found there were some generic risk assessments completed in relation to people's health care needs but many were found to be inaccurate, out of date and absent. We observed one person experienced a choking episode on 18 June 2015, despite their identified swallowing difficulties, there was no risk assessment to reduce the risk of choking in place before this incident or put in place afterwards. The nutritional risk assessment for this person showed the scoring and risk status had decreased in recent months despite a deterioration in their health needs.

Risk assessment records in people's care files were not reviewed even when there was a clear change in need. For example, one person had developed a pressure ulcer yet their risk assessment for skin damage still indicated they were 'low/medium' risk and directed staff to check their skin condition each week. Another person had sustained a compound open fracture on two ankle bones in March 2015 following a fall; there were no assessments in place for mobility or falls to reduce risk of reoccurrence and prevent further injury; records showed this person had experienced a further fall recently.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014. The registered provider had not taken steps to assess the risks to the health and safety of people living in the home.

On 18 June 2015 there were 25 people residing at the home. There were four care staff on duty in the morning, three in the afternoon, four in the evening and three at night. We found these staffing levels were not sufficient to meet people's needs. Staff could not monitor people who used the service effectively and they were over stretched with the work load. We observed people who used the service were left unattended for long periods of time in communal areas. There was no interaction between care staff and people other than during the delivery of care. Call bells rang continuously, people had to wait for support with personal care and toileting. The inspector and expert by experience had to call for assistance for people on a number of occasions. Two people who walked with purpose throughout the day were not monitored by staff. People were left unattended at lunchtime and one person left the table and fell resulting in a head injury. One visiting professional described the service as, "Chaotic, with a lack of coordination." Another professional described how they regularly entered the home, found their patient, carried out their consultation and left without staff knowing they had visited.

The registered manager used a dependency tool to calculate the staffing hours required, however, records showed this had not been updated and reviewed since 7 May 2015. On 19 June 2015 we asked to see the information to support people's current dependency figures, but these could not be found. The deputy manager confirmed people's dependency levels had increased significantly over the last month and deployed additional care workers to support the routines.

Inadequate

Is the service safe?

We found the number of hours for ancillary work such as cleaning and laundry were inadequate and shortfalls in these areas had been passed on to the care staff to manage, which impacted on the care and support for people. The activity person had been on maternity leave for several months and no additional hours for activities or temporary cover had been provided in this time.

On the 18 June 2015 the registered manager confirmed their intention to resign from their position and they handed in their notice. They were then absent from the home due to time off and sick leave. The deputy manager was given day to day managerial responsibility by the registered provider. The deputy manager expressed serious concerns about the shortfall of senior staff cover at the service on each shift due to staff absence from sick leave and holiday leave. There was particular concern about the night shifts and lack of staff who were trained and competent to administer medicines. Senior cover was arranged and agreed with the registered provider during the inspection, however, North East Lincolnshire Clinical Commissioning Group were so concerned that on 19 June 2015 they commissioned staff from an external source to work at the service to support the staff and to ensure people's needs were safely met.

These issues meant there was a breach of Regulation 18 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014. The home did not have sufficient staff on duty to meet people's needs safely.

We found medicines were ordered and stored appropriately. We found an administration issue which required improvement and some minor recording issues. For example, we saw one person with memory impairment was left their medicines in a pot in front of them. This meant staff did not observe when they had taken them although they have signed the medication administration record. We passed this on to the deputy manager to address. On the first day of our inspection we saw the senior care worker's medication round was interrupted four times in a 15 minute period; when we asked about this we were told this typically happened and medication rounds were frequently interrupted because there were not enough staff available to people.

We looked at three staff recruitment files and saw staff were only employed after appropriate checks had been carried out. These included references, gaps in employment, an interview and checks with the disclosure and barring service to make sure staff were safe to work with vulnerable people.

Inadequate

Is the service effective?

Our findings

People we spoke with told us they enjoyed the meals provided and there was always a choice. Comments included, "Lovely meals I really enjoy them" and "Meals are very nice." We spoke with relatives who were concerned about their family member's weight loss; they did not feel enough was being done to encourage and monitor an adequate intake at meal times. They also told us they were concerned the weight loss was not being followed up by the dietician.

During the inspection we found serious concerns regarding the management of people's health care needs, the timeliness of seeking professional advice and the poor arrangements for ensuring staff were following any professional advice and direction provided.

Discussions with staff and records showed where people were losing weight, more regular monitoring was not put in place and concerns not always reported to their GP or dietician and followed up. For example, one person had lost a significant amount of weight (6.1kgs) during April and May 2015, yet this concern had not been passed to the GP and more frequent monitoring was not taking place. There had been no weight assessment for June 2015 at the time of the inspection. A communication record in the person's care file indicated staff had spoken with the dietician on 16 March 2015 who confirmed they would provide nutritional supplements and directed staff to provide fortified milkshakes. We found this person's care plan for nutrition was not dated and did not detail any issues with weight loss or provision of a fortified diet. When we asked the deputy manager about the supplements they confirmed these had not been obtained.

We found another person had lost 4.1kgs in four months. There were no records to demonstrate that continued weight loss had been passed to the GP and more frequent monitoring was taking place. A hospital discharge summary record in another person's care file dated 14 June 2015, recommended that the GP referred the person to the dietician. There were no records on 19 June 2015 to support the referral had been followed up and made. This showed people who were losing weight were not referred for professional assessment of their nutritional needs, having regard to their well- being.

One person's care file showed they had experienced a number of falls recently and sustained injuries such as bruising and skin tears. The accident record dated 3 June 2015 detailed they had fallen and sustained large skin tears to their shoulder, elbow, hand and knee. A communication record detailed criticism from the community nurse who had been contacted to visit and review the person's skin damage sustained from this fall. We spoke directly to the community nurse who said the staff on duty on the 3 June 2015 had not called the paramedics as they should have done for this level of injury. The home staff had not carried out necessary wound care and had not applied the dressings appropriately. When the wounds had leaked the following day and community health staff were called in to review, further skin damage was caused when the dressings had to be removed. This meant the person did not receive the appropriate emergency care and treatment they required for injuries sustained following the fall.

During the inspection we witnessed one person choking whilst being supported to eat vegetable soup for their evening meal. This person's care records showed they had been assessed by the speech and language therapist [SaLT] in January 2015 and detailed directions on food texture and consistency of food and fluids had been provided. This information had not been incorporated into their care plan. The soup the person was eating was not of the texture or consistency which the SaLT had detailed in their report. The registered manager told us the chunks of carrot were soft and that a thickening agent had been added to the soup. However, when we spoke with the cook they confirmed they had not blended the soup or added thickening agent prior to the meal leaving the kitchen. This meant the guidance provided by the SaLT had not been followed and the meal provided to this person put them at risk of choking, aspiration and harm.

These issues meant there was a breach of regulation 12 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014. The registered provider had failed to ensure the safe care and treatment of people living at the home.

We found the application of the Mental Capacity Act 2005 [MCA] in regards to assessments of capacity, best interest decision making and care planning was poorly applied. Where people who used the service lacked capacity to make an informed decision or give consent, staff had not acted in accordance with the MCA and associated code of

practice. For example, care files showed decisions had been made in relation to people's end of life choices and administration of covert medicines but there were no capacity assessments in place to support these decisions. Eight 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.

We found physical interventions and restraint were used without appropriate consent, staff training and recording systems in place. Records showed two people regularly demonstrated a high level of verbal and physical behaviours when staff tried to deliver personal care. Both people had Deprivation of Liberty Safeguards [DoLS] in place which did not identify that any form of physical intervention was needed to meet their needs. One person's risk assessment directed staff to use restraint if necessary and another person's care plan detailed that care should be provided in their 'best interests.' When we asked staff what this meant, they said that they could provide personal care by holding the people's hands and stopping them from lashing out. The registered manager also told us this. When we asked staff to describe the type of holds they used, they gave differing accounts. 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. Daily records for people described how personal care had been provided in their 'best interests' when they demonstrated very aggressive behaviour. There were no records of the type of holds used, time, duration of hold, staff involved or de-brief records which are necessary to support the use of restraint and physical intervention.

The registered manager and staff did not understand that unlawful restraint practices were used regularly in the service. Seventeen staff had attended a course on management of difficult behaviour and this course did not equip staff to restrain people safely using least restrictive practice. Although concerns about the use of physical interventions at the service had been discussed at the safeguarding strategy meeting held on the 11 June 2015, we found no evidence during the inspection that the registered manager and registered provider had taken any further action to protect people from harm, when they demonstrated behaviours which challenged the service during the delivery of personal care. On the 18 June 2015 we found a record in one person's file dated 17 June 2015 which indicated staff were continuing to restrain the person on their upper arms when delivering personal care. We informed the safeguarding officer for North East Lincolnshire safeguarding team who visited the service on 19 June 2015 with the person's social worker.

During the inspection we found records which indicated staff were locking one person in their room at night. We reported this concern to the safeguarding manager for North East Lincolnshire Adult Safeguarding Team. A safeguarding officer visited Hadleigh House to investigate the concern on 24 June 2015. Information provided by the deputy manager on the 25 June 2015 indicated that the majority of staff who worked night duty had confirmed they regularly locked two people in their rooms at night. This was unlawful restraint. These concerns were passed to Humberside police.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014. 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 had been subject to unlawful restraint.

The Care Quality Commission is required by law to monitor the use of Deprivation of Liberty Safeguards [DoLS.] DoLS are applied for when people who use the service lack capacity and the care they require to keep them safe amounts to continuous supervision and control. There were nine people subject to a DoLS at the time of this inspection and another five application for a DoLS had been submitted to the local authority.

We looked at training records which showed staff had completed a range of training sessions. We found some staff had not had recent refresher training in some key areas. Some of the training did not equip staff with the necessary skills to meet the needs of the people they cared for and we found little evidence of senior staff supervising and monitoring staff competence in carrying out their role.

The majority of care staff had attended training in the Mental Capacity Act 2005 [MCA], however 50% of staff had attended this in 2011 and there was no evidence of any refresher courses arranged. In discussions with staff we found they lacked understanding of how and when this would be applied.

Inadequate

Is the service effective?

Records showed seven staff had not attended fire safety training and the majority of other staff had completed the course in 2013. We asked the deputy manager how often staff should receive refresher training and they confirmed staff should attend this annually.

Records also showed 17 of the care staff had attended a course on 'managing difficult behaviours' in August and October 2014. This course did not equip them to safely and competently use physical interventions and restraint. When we discussed this with the registered manager they told us the registered provider had refused to fund a more appropriate training course. This meant there was a risk people who used the service would not be supported safely and staff may use excessive force and may injure people or themselves in the use of any physical interventions; this practice was also unlawful.

We found staff who administered medications had completed the safe handling of medicines course. Records showed the registered manager had assessed the competency of six senior care workers with administration of medicines in January and May 2014. There were no records of competency assessments completed for the care workers on night duty who administer medicines, to ensure their practice was safe. Neither did we find evidence of any competency assessments completed after staff had made medication errors, to ensure their practice was safe.

There was a lack of staff supervision and appraisal taking place. Out of 40 staff, 10 had received supervision in June 2015. Checks on other staff files showed some staff had not received supervision for over six months or at all. There was no plan for staff supervision. It took place randomly. The deputy manager confirmed they had not received any supervision for years; when we checked their file we found no supervision records.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014. This was because staff had not received training, supervision and professional development to enable them to deliver care and treatment to people in the home safely and to an appropriate standard.

We found there were limited environmental adaptations to support people living with dementia; people had photographs on their bedroom doors, there was some pictorial signage and two coloured toilet seats to aid orientation. The majority of carpets and flooring throughout the home required replacement as they were heavily stained and worn. The flooring in all the toilets on the ground floor was stained and worn. There was a split in the join of the main lounge carpet which posed a trip hazard.

A toilet on the ground floor was leaking. The pipe at the back of another toilet on the ground floor was cracked and there were cracks in the sides of two baths. The radiator cover in one bathroom was broken. A section of the stone hearth in the fireplace in the lounge was cracked and broken. The privacy lock on one person's room door was broken. We noted the chair raiser for an arm chair was broken but still in use, we mentioned this to the staff to address during the inspection. This meant there was no effective system to ensure appropriate repairs and renewal was carried out.

The majority of furniture throughout the service was worn and marked. The dining tables and chairs were heavily marked; none of the dining chairs had arm supports or gliders to assist people to manoeuvre and ensure their support and comfort. Table cloths were also worn and frayed. Pillows and duvets were worn. Twelve of the arm chairs in sitting rooms were worn and the vinyl covers on the arms were ripped and the wooden legs were marked. Coffee tables were worn and marked. We found many items of furniture such as bed side tables, chest of drawers, head boards, bed bases, chairs and wardrobes in bedrooms required repair or replacement where they were worn, marked and chipped. Paintwork throughout the home was found to be dirty, marked and worn.

We found storage was poor in the home which impacted on people's safety. There were seven vacuum cleaners stored in corridors. The domestic worker said the registered provider continued to provide domestic style cleaning equipment which was ineffective and broke easily. Equipment and furniture was stored in bathrooms. A large hoist was charging in the dining room. There were three broken chairs in the dining room, one had a leg missing and a note on it read 'do not sit.' In one of the lounge areas there were large amounts of activity equipment stored in piles on the floor behind two arm chairs. This meant people weren't protected from the risk of falling over equipment and faulty furniture causing harm.

This was a breach of Regulation15 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014. The

Inadequate

Is the service effective?

premises were dirty and poorly maintained. Little consideration had been made towards adapting the premises to ensure the home was suitable for people living with dementia.

We observed three 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 service was slow and some people were sat waiting for their meal for up to 30 minutes; we observed staff were rushed and there was little interaction when serving the meals.

We observed the cook spent time speaking to each person about their meal choices for the day. We talked to the cook, about specialist diets, including enriching food for those needing a high calorific diet and how individual tastes and preferences were catered for. The cook had a good knowledge about specialist diets and could give an account of how additional nutrition was provided for those at risk of malnutrition. Despite this, we observed only biscuits were provided mid-morning and mid-afternoon with drinks and this was a missed opportunity to offer a range of high calorie snack options to supplement the diet for people who needed encouragement to increase their nutritional intake.

Inadequate

Is the service caring?

Our findings

We asked the people living in the home if the staff were caring. Most people responded positively about the staff. People's comments included: "Yes, they are, they do anything you want", "The staff are pretty good here" and "More than happy with the care." However, one person we spoke with told us, "They [care staff] are always too busy to spend time with you. Some of them are much kinder than others; the nice ones are alright but some don't listen to me, about what I want."

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

We noted overall that staff spoke with people in a kind and friendly way. Whilst they tried to support people appropriately, they lacked some understanding about people's dementia needs and the relevance of people's behaviours. We also saw some evidence that staff had a task based approach to care and did not always promote and protect people's dignity and privacy. For example, during lunch a member staff entered the dining room and spoke to another member of staff about a person, who was named, having a GP appointment and needed to be 'toileted' after their meal. This was clear for everyone to hear. Later we also overheard a member of staff say to a colleague, "She's been pressure relieved."

During lunch we observed a person requested support from a member of staff for assistance to go to the toilet and the member of staff was reluctant to provide this support and tried to persuade this service user on three occasions to wait until after lunch. We observed the person chose to go to the toilet and two staff provided the necessary support. By the time the person was brought back from the toilet, their lunch, which they were told would be saved for them, had been taken away. Although the person expressed dissatisfaction about this, the member of staff did not listen to the person and try to address their concerns.

We noted on the first day and second days of the inspection that some people did not look well cared for. Their clothes were dirty and stained and their hair was not brushed. A number of men needed a shave. After meals we saw people with food left on their hands, faces and clothing. People were not always supported to remove their clothing protectors after their meal which were covered with food debris. We found the standard of personal care had improved on the third and fourth days of the inspection.

Visitors told us the care of their relative's clothes and laundry could be improved, as clothes had gone missing, clothing wasn't ironed properly and other people regularly wore their relative's clothing. We found there had not been time for staff to attend to people's clothes properly. There were large boxes of unlabelled clothing in the laundry, which needed to be sorted and returned to their rightful owners.

We undertook a tour of the home and we saw other examples of how people did not have their dignity needs met. For example, we found many bedrooms and communal areas were poorly furnished, dirty and there were strong mal odours of stale urine which further indicated a lack of regard for people's dignity.

We found some people's bedrooms also required attention to make them look homely, comfortable, lived in and to provide stimulation for people living with dementia. We found some bedrooms looked very personalised with pictures, photographs of family and memorabilia to aid stimulation and memory recall. However, other bedrooms looked quite stark with few ornaments, pictures and personal items. We found a large amount of notices in people's bedrooms directing staff on things such as aspects of people's care and laundry arrangements. It was clear many of the notices had been in place for a long time as they were water stained, ripped and peeling off the wall. This also did not promote people's dignity and did not support a comfortable, homely environment.

The deputy manager showed us a record they had recently put in place when people were supported with baths and showers. They said they had done this as they were concerned people were not receiving the support they needed or preferred. We checked the bathing records and found lots of gaps. Some people had not received support in the last four weeks.

Inadequate

Is the service caring?

This was a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People's dignity and privacy wasn't properly supported and protected.

We observed the staff talking to and supporting the people who lived in the home during care tasks. The staff were caring in their approach and appeared to have positive relationships with the people they were supporting. However, we did see staff did not have time to spend interacting with people as all their time was spent carrying out very basic personal care for people. We did not see much evidence of staff working in partnership with people to improve and maintain their life skills and independence.

We observed notice boards were crammed with information which meant people could not access and read the information easily. There was information about advocates on display in the service; records showed advocates had been involved in supporting people to make important decisions about their life.

Inadequate

Is the service responsive?

Our findings

People and their relatives told us they would feel able to complain and these would be listened to and sorted out. They said, "I do raise them with the manager and staff. To be fair they are actioned", "I would if I had one, I don't complain" and "I would know what to say."

People told us they did not participate in any activities. One person told us they did nothing all day and another person told us they enjoyed playing dominoes, skittles and doing crosswords with the activity co-ordinator but this had not been for a long time. A relative told us, "I sometimes wonder if there's enough. I am not aware of anything regular. It would be nice if they did reminiscence work individually or as a group."

We found serious concerns in the way people's care and welfare was managed. We found 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.

The majority of people in the service had dementia related needs. Life biographies were only completed in two of the files we checked. When staff do not know or understand about people's past they may not talk to them in a meaningful way, or provide social activities either within the service or the community that are of interest to them. There was no evidence of any involvement from people or their relatives in the design of the care plans we looked at. People's individual preferences for how they wished their care to be delivered were not recorded, apart from very basic information. Much of the documentation was generic not individualised and specific for each person.

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, personal care and nutrition. We also saw many examples where areas of need had not been assessed and planned for. For example, one person had fallen and sustained an open fracture of the bones in their ankle; they underwent surgery and were discharged to the home with a plaster cast. We found no care plans were in place to direct staff with the support this person required in relation to their mobility, pain or care of the cast. Records showed they had fallen again recently. Another person required full support to manage their stoma, we found there was no care plan in place to direct staff on the support the person needed.

During the inspection one person experienced a fall; we found there was no care plan in place to support the person's mobility and prevention of falls, nor was this put in place afterwards. We also observed another person experienced a choking episode during the inspection and their care plan had not been updated to reflect their current needs in relation to their swallowing difficulties.

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 communication record for 17 June 2015 showed they had sustained pressure damage on their sacrum. When we spoke with three care workers and a senior care worker they were not aware of this. A care plan for pressure relief was in place but had not been updated to reflect the person's needs had changed and the frequency of repositioning support should be increased. The plan in place directed staff to check the person's skin condition each week. When we asked staff if they provided regular repositioning support to this person they confirmed they did not, and the person could move in the seat independently. During the inspection on 18 June 2015 we observed this person remained in the same position for most of the day. Checks on repositioning records for 18 June 2015 were not completed. This meant this person was at risk of their pressure damage worsening. We spoke with a visiting health professional during the inspection who confirmed they had reviewed this person's care file. They said the care plans were out of date and not personalised; they did not reflect the care the person required. They confirmed they had instructed the community nurse to complete an assessment of the person's skin condition.

Discussions with staff confirmed one person was receiving end of life care. We found none of their care plans and risk assessments had been reviewed since April 2015. Therefore appropriate care plans were not in place to support the person's current needs in relation to their personal care; pain control; nutrition/ hydration, prevention of pressure damage, continence and spiritual needs.

Records we checked showed three people regularly demonstrated behaviours that could challenge the service.

Inadequate

Is the service responsive?

However, care plans were not in place to identify any 'triggers' that may cause the person to become angry or upset. If these triggers are not known or identified, then staff cannot work to avoid those situations. Similarly we did not see records in their care files relating to how best to communicate with the person, or what different behaviours or mannerisms may mean. People with mental health illness often struggle to put into words their own needs and wishes, so people needed extra support to identify these preferences and choices so that these can be known and planned for.

Records showed the community mental health team had completed an assessment for one person on 11 June 2015 and provided a report which gave staff detailed guidance in how to support the person when they demonstrated behaviours which challenged the service. We found this had not prompted staff to develop a behaviour management plan and the daily communication records showed the guidance was not being followed.

Staff confirmed they did not read people's care files as they didn't have sufficient time to do so. They said they relied on handover meetings and communication books to inform them of people's care needs and any changes, they did confirm things got missed. One member of staff said, "We don't have time to read the care plans, they aren't up to date anyway. We have regular handovers but communication has been a big issue recently, we are always so busy and things get missed."

Recording of people's needs and preferences in relation to their social and recreational needs was minimal. Some people's care files included brief social histories but others did not. People were sitting in the lounges or their bedroom with no meaningful activity or positive interaction taking place. We saw the lounges were left unattended by staff for long periods of time as there was insufficient staff available to support people. We asked about activities and we were told there were few taking place. During the four days of the inspection we observed one activity taking place; this was a game of skittles. We were told by staff the activities co-ordinator was on maternity leave and cover had not been arranged. They told us they had provided activities themselves when they could, however we found no records to support any activity provision in recent months. There was no activity programme and no evidence of any external entertainment provided. We observed two people walked with purpose around the home, however when they arrived at their destination there was nothing for them to do; for example there were no rummage boxes or magazines and books for them to look through.

These issues meant there was a breach of Regulation 9 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014. This is because people living in the home were not receiving person centred care.

The registered manager maintained a log of complaints. Records showed four complaints had been received in the last 12 months. We saw these were recorded and investigated appropriately. Staff knew how to manage small and informal complaints and said written or formal complaints would be referred to the registered manager to address.

Inadequate

Is the service well-led?

Our findings

The quality monitoring programme at the service were ineffective. We found checks on how the service was operating were not being routinely completed in any detail, the risk of harm to people was not being assessed, managed or kept under review, and the staff were not well supported.

The registered manager was present for the first day of the inspection although they confirmed they had handed in their notice to resign; they were not present for the remainder of the inspection. This left the deputy manager and administrator to manage the day to day running of the service. As the inspection progressed and further serious concerns were identified it became clear the acting management team were struggling to take appropriate action to make the necessary improvements. They confirmed they did not have the resources and were not skilled and competent to continue to manage the service.

We found the care staff lacked leadership and management support. Staff morale was low. Communication within the service was poor and staff did not know key information about people's care needs or their legal responsibilities in terms of the Mental Capacity Act 2005. We found evidence that indicated people were being unlawfully restrained.

Policies and procedures did not reflect current best practice guidance. For example, the restraint policy dated 2015 did not refer to the Department of Health guidance dated April 2014, on 'Positive and proactive care reducing the need for physical interventions.' The home's restraint policy did not refer to the use of 'least restrictive practice' with physical interventions. This meant nationally recognised guidance which should underpin staff practice to ensure the safety, health and welfare of people who used the service had not been implemented.

The quality monitoring programme in place at the home was poor and there was little evidence of any comprehensive audit tools used. For example, no records were available to support any actual checks on care records, standards of hygiene, safeguarding incidents, incidents of behaviour which challenged the service, activities, weights, accidents and incidents, pressure damage, complaints and concerns, staff training or supervision monitoring. The whole system was a tick box exercise by the registered manager and very few shortfalls were identified.

We had concerns about risk management and follow through to ensure all staff were aware of risks posed to people who used the service. For example, risk assessments had not been completed following some very serious incidents. There was no system to analyse the incident, check whether a risk assessment was needed or follow this up with staff to ensure it had been completed and cascade information to staff.

There were no effective systems in place that ensured people's needs were assessed, monitored and reviewed properly to inform their care planning. We found care plans were not personalised, up to date and contained very little information to enable staff to provide safe care. Neither were there any systems in place to check monitoring charts for areas such as food and fluid intake or pressure relief had been completed at the end of each shift. We found significant gaps in the supplementary monitoring records for people. We found evidence that people's care needs were not being met.

External audits on infection prevention and control and pressure damage had been completed on 20 November 2014 by the care home liaison team at North East Lincolnshire Clinical Commissioning Group. Both audits failed to achieve compliance and significant deficiencies were identified and action plans provided. We found no evidence of action taken to make the necessary improvements, moreover the inspection highlighted there had been further deterioration and shortfalls.

There was no effective system in place for renewal to ensure the premises were clean, safe and well maintained. There were no full and detailed audits of the environment in place. There was no annual maintenance/ renewal programme in place. The administrator completed monthly management reports which had identified longstanding environmental issues around odour management, poor furnishings, carpets and décor. The Care Quality Commission [CQC] inspection report dated September 2013 also identified improvements needed around carpet renewal. Healthwatch North East Lincolnshire had visited the home to carry out an 'enter and view' visit on 12

Inadequate

Is the service well-led?

November 2014. The report of this visit detailed a smell of urine was identified in the bedroom corridor areas. There was no evidence of any action taken to make sustained improvements or extra provision to manage this.

Supplementary monitoring records were poorly completed. There were gaps in records which showed when people were repositioned and how much food and fluid they had taken. Staff reported the registered manager had introduced new 24 hour monitoring forms but they did not have time to complete these properly. We found these records were incomplete. There was no checking system in place and without this it was difficult to audit the correct care had been given to people.

We found audits of medicines had been completed in January 2015. We saw there were appropriate systems being used for the safe storage of medicines. However, when errors in the administration had occurred, steps were not always put in place to minimise the risk of these errors occurring again in the future. Staff who had made the errors were not given additional training and assessed as being competent to administer medicines following the errors.

These examples are all breaches of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This is because there were no effective systems or processes in the home to ensure that the service provided was safe, effective, caring,responsive or well led.

Resident meetings were held every three months. Records showed issues raised by people were not always addressed. For example concerns about laundry were identified in most meeting records. Similarly suggestions about meals with changes to portion size and menu choices were not followed up. A request for a call bell in one lounge area had not been actioned.

The registered manager was required to send the CQC notifications of incidents which affect the safety and wellbeing of people who used the service. We found there had been at least 13 occasions when incidents had occurred since June 2014 which required a notification to CQC but our records indicate we did not receive them. Notifying the CQC of incidents which affect the health and welfare of people who use the service enables us to check with the registered manager how these are being dealt with.

This was a breach of Regulations 18 of the Care Quality Commission [Registration] Regulations 2009.

The ineffectiveness of the registered provider's system of quality and risk auditing was demonstrated through the breaches of regulations we found during this inspection that had not been identified by the registered provider before our visit. We shared our serious concerns with the registered provider who was not able to explain why there were so many issues of concern in the home that had not been dealt with and considered the acting manager and the administrator would be able to sort things out. There was a clear failure on behalf of the registered manager and the registered provider to carry out the regulated activity. There was evidence of their lack of competence, skill and knowledge.

This meant there were breaches of Regulations 5 and 7 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014. The findings of the inspection showed the registered manager and director of Hadleigh Care Limited were not competent, experienced and skilled to carry on the regulated activity.

During the period that the inspection took place we raised our concerns with both the deputy manager and the registered provider and requested that urgent action was taken to mitigate the immediate and extreme concerns. The deputy manager submitted an action plan that told us what immediate action had been undertaken but much of the future actions to be taken were aspirational and dependant on decisions by the registered provider. The registered provider had not contributed to the action plan and was not available to support the interim management team in place. We found that sufficient and timely action had not been taken and we found a continued and serious risk to the people's lives, health and well-being.

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 5 HSCA 2008 (Regulated Activities) Regulation 2010 Requirement where the service provider is a body other than a partnership **The findings from the inspection and lack of action taken in respect of the serious concerns raised demonstrated that the director did not have the competence, skills and good character which are necessary to carry on the regulated activity.**

The enforcement action we took:
CQC used its urgent powers to apply to the Magistrates Court on 29 June 2015 and received a court order to cancel the registered provider's registration to carry out the regulated activity at Hadleigh House Residential Home.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 7 HSCA (RA) Regulations 2014 Requirements relating to registered managers **The findings from the inspection demonstrated that the registered manager did not have the competence and skills which are necessary to carry on the regulated activity.**

The enforcement action we took:
CQC used its urgent powers to apply to the Magistrates Court on 29 June 2015 and received a court order to cancel the registered provider's registration to carry out the regulated activity at Hadleigh House Residential Home.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **People living in the home were not receiving person centred care.**

The enforcement action we took:
CQC used its urgent powers to apply to the Magistrates Court on 29 June 2015 and received a court order to cancel the registered provider's registration to carry out the regulated activity at Hadleigh House Residential Home.

Regulated activity	Regulation

This section is primarily information for the provider

Enforcement actions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect The registered provider did not have suitable arrangements in place to ensure people living at the home were treated with dignity and respect and ensured their right to privacy.

The enforcement action we took:
CQC used its urgent powers to apply to the Magistrates Court on 29 June 2015 and received a court order to cancel the registered provider's registration to carry out the regulated activity at Hadleigh House Residential Home.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent **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.**

The enforcement action we took:
CQC used its urgent powers to apply to the Magistrates Court on 29 June 2015 and received a court order to cancel the registered provider's registration to carry out the regulated activity at Hadleigh House Residential Home.

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 provider had not taken steps to properly assess the risks to the health and safety of people living in the home. The premises were not safe. Systems to support effective infection prevention and control were not safe.

The enforcement action we took:
CQC used its urgent powers to apply to the Magistrates Court on 29 June 2015 and received a court order to cancel the registered provider's registration to carry out the regulated activity at Hadleigh House Residential Home.

Regulated activity	Regulation

This section is primarily information for the provider

Enforcement actions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **The registered provider did not have adequate arrangements in place to protect people from harm or abuse.**

The enforcement action we took:
CQC used its urgent powers to apply to the Magistrates Court on 29 June 2015 and received a court order to cancel the registered provider's registration to carry out the regulated activity at Hadleigh House Residential Home.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment The premises were dirty and poorly maintained. Little consideration had been made towards adapting the premises to ensure the home was suitable for people living with dementia.

The enforcement action we took:
CQC used its urgent powers to apply to the Magistrates Court on 29 June 2015 and received a court order to cancel the registered provider's registration to carry out the regulated activity at Hadleigh House Residential Home.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance **There were no systems or processes in the home to ensure that the service provided was safe, effective, caring, responsive or well led.**

The enforcement action we took:
CQC used its urgent powers to apply to the Magistrates Court on 29 June 2015 and received a court order to cancel the registered provider's registration to carry out the regulated activity at Hadleigh House Residential Home.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing **The home did not have sufficient staff on duty to meet people's needs safely. Staff had not received**

This section is primarily information for the provider

Enforcement actions

training, supervision and professional development to enable them to deliver care and treatment to people in the home safely and to an appropriate standard.

The enforcement action we took:
CQC used its urgent powers to apply to the Magistrates Court on 29 June 2015 and received a court order to cancel the registered provider's registration to carry out the regulated activity at Hadleigh House Residential Home.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents The required notifications had not been made to CQC.

The enforcement action we took:
CQC used its urgent powers to apply to the Magistrates Court on 29 June 2015 and received a court order to cancel the registered provider's registration to carry out the regulated activity at Hadleigh House Residential Home.