Haldane House Limited

Haldane House Nursing Home

Inspection report

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13 June 2016

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Inadequate**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

The inspection took place on 08, 10 and 13 June 2016 and was unannounced. We last inspected the service in June 2014. At that inspection we found the service was compliant with all the essential standards we inspected.

Haldane House is a care home with nursing. It provides accommodation and nursing care for up to 25 people. Some of the people using the service are living with dementia. The home is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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.

At the time of the inspection there was a registered manager at the service. They assisted with the first day of the inspection before going on leave. The deputy manager and general manager assisted with the second and third days of the inspection.

Risks to people's safety were not always assessed and when they were, the assessments were not always accurate or acted upon. Measures were not always taken to reduce or manage the identified risks to people's safety and well-being.

Although the service was generally clean and tidy we found scale on sinks and taps as well as damage to furniture, exposing areas which may harbour bacteria.

The provider did not have a comprehensive contingency plan in place to ensure the safe continuation of the service in the event of a foreseeable emergency. Health and safety audits were completed but did not always identify risks to people.

Staff did not always understand their responsibilities to safeguard people. Accidents and incidents were not always reported or investigated.

Staff were recruited safely but there was no system in place to determine how many staff were required to meet people's need effectively.

Medicines were managed safely and people received them when they needed them. People had access to effective healthcare from a GP and other healthcare professionals when required.

People were provided with nutritious food tailored to their choice and tastes. When necessary people's food and fluid intake was carefully monitored.

Although staff told us they felt supported we found they did not always receive the training and supervision

that they needed to meet people's needs effectively.

Staff sought people's consent before offering care. However, not all staff understood their responsibilities with regard to the Mental Capacity Act 2005 (MCA). Therefore we could not be assured people's rights to make decisions were always protected.

People's privacy and dignity was not always respected. There was lack of opportunity for people to spend time alone or with their visitors. Care was not always focussed on individual people but more on completion of tasks and routines.

People were treated with kindness by friendly and attentive staff. People and their relatives spoke highly of the staff team and praised their hard work.

The provider did not have an effective governance system to monitor the quality of the service. Effective audits were not carried out and the provider had not identified the issues we found at this inspection.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have asked the provider to take at the end of this report. CQC is also considering other appropriate regulatory response to resolve some of the concerns we found and will report on any
action taken when it is completed.

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.

Risks to people's safety were not always assessed and monitored appropriately.

People were not always protected from the risk of abuse. Accidents and incidents were not always reported and investigated.

Infection control risks had not been addressed.

People received their medicines when they required them. Medicines were managed, stored and disposed of safely.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff had not always received the training, guidance and support they needed to enable them to carry out their job effectively.

Not all staff understood the principles of the Mental Capacity Act and Deprivation of Liberty Safeguards. People's rights to make decisions were not always protected.

People were supported to eat a nutritious diet in sufficient quantities to maintain their well-being.

People's health needs were managed effectively. Health professionals were contacted when people became unwell.

Is the service caring?

Requires Improvement

The service was not always caring.

People were not always provided with privacy and dignity.

Staff treated people with kindness and showed patience toward people.

Relatives were positive about the care people received.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's needs were not always met in a personalised way.

People and their relatives were able to give feedback on the service.

Information about how to make a complaint was available. When concerns had been raised they had been dealt with.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The provider did not have effective quality assurance and risk management systems to consistently identify issues or to improve the service.

People, staff and relatives spoke highly of the registered manager and felt they were approachable and open.

Haldane House Nursing 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 provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service and to provide a rating for the service under the Care Act 2014.

The inspection was carried out by one inspector on 08 and 13 June 2016 and an inspector and a specialist professional advisor on 10 June 2016. A specialist professional advisor is someone who has a specialist knowledge and experience in the service being inspected such as dementia. The inspection was unannounced and it was a comprehensive inspection.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

Prior to the inspection, we reviewed the information we held about the service. We looked at statutory notifications that had been submitted by the service. Statutory notifications include information about important events which the registered provider is required to send us by law. We contacted the local authority commissioners to obtain feedback from them about the service. We looked at information received about the service from other people and stakeholders and we reviewed previous inspection reports.

During the inspection we spoke with ten members of staff, including the registered manager, the general manager, the deputy manager, one registered nurse, four care staff, a member of the kitchen staff and a maintenance worker. We spoke with five people who use the service and two relatives.

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 watched a medicine round and attended a staff handover. We spent time observing activities in the communal areas of the service.

We reviewed seven care plans and associated records including medicine administration records. We examined a sample of other records relating to the management of the service including staff training and supervision records, complaints, accident and incident reports, surveys and various monitoring and audit tools. We looked at the recruitment records for three recently recruited staff. We also reviewed documents relating to health and safety, for example, servicing certificates for equipment and risk assessments for fire and legionella.

Inadequate

Is the service safe?

Our findings

At the time of the inspection there were 24 people living at Haldane House. During the inspection most people were seen to be spending their time in the main lounge. Some people were able to speak with us but many found it difficult to give us their views due the conditions they were living with. People who were able to speak with us said they felt safe, however, we found people were not always safe at Haldane House.

Assessments had not always been carried out to identify risks. In two people's care files we saw there were no risk assessments. Therefore, no actions had been identified and no guidance was available for staff to follow in order to reduce the risks to people's safety. We were told this was because the people were new to the service. However, both had been living there for at least nine days. On the first day of the inspection one of these people wanted their seating position adjusted as they were uncomfortable. Staff acknowledged the person's request but we saw they did not know the most suitable and safe way to move the person. Three staff members positioned themselves as though they were about to physically lift the person however, another staff member intervened and suggested a handling belt or a standing hoist was used. The person was then repositioned safely using a standing hoist. We checked the records and saw no assessment had been carried out and there was no safe system of work for staff to follow in order to move this person safely. We raised this with the deputy manager who completed a risk assessment and a safe system of work by the second day of the inspection.

Where assessments had been carried out to assess identified risks they were not always accurate or acted upon. On the second day of the inspection we found one person was using a profiling bed in a raised position with bed rails that had no bumpers. Bumpers are fitted to minimize the risk of entrapment. A crash mattress was in use on one side of the bed but not on the other and there was no alarm pad in place to alert staff should the person fall. A member of staff told us that "This (service) user has challenging behaviour and he deliberately tries to jump over the crash mattress when it is placed near his bed to miss the crash mattress. He is also verbally and physically aggressive." This person was at risk of injury should they try to get of bed by climbing over the bedrails. We brought this to the attention of the deputy manager and area manager. They lowered the bed to its lowest position and removed the bedrails from use. As this person shared a room with another person, additional staff checks were implemented to ensure the safety of both people.

We checked the records for this person and found there were risk assessments in place including one for the use of bedrails. However, the plan to manage the identified risks was incomplete. It did not identify all the behaviour which may put this person at risk, nor give appropriate actions or guidance for staff to follow to reduce these risks. The risk assessment also identified bumpers should be used with the bed rails to reduce the risk of entrapment. However, they were not in place during the inspection. The general manager and deputy manager requested an urgent review of this person's care with appropriate health professionals and agreed to review the risk assessment and care plan.

As a result of the concerns found with this person the Care Quality Commission inspection team raised a safeguarding alert with the Local Authority safeguarding team.

This was breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff had received training in safeguarding people and some were able to describe the types of abuse people may be subject to and the signs that may indicate this. For example, one member of staff told us a change in a person's behaviour may indicate they had been abused and added, "We know our clients well and notice things very quickly." They went on to say, "We are here to look after and protect the people." However, despite having received training we found that other staff members were unable to explain what safeguarding people meant or describe any types of abuse or signs to look for.

Staff said they would have no hesitation in reporting any concerns regarding people's safety to the senior staff. They were confident it would be taken seriously and escalated to the appropriate authorities. However, we found examples of bruising which had not been reported in order for an investigation to be conducted. In one instance, on the morning of the third day of the inspection we noted one person had a bruise on their face. This had been noted in the care notes which stated, "[Name] hit his eye on side of bed, a little bruise by side of eye." However, no body map or accident form had been completed. We saw another person had unexplained bruising on their arm, again there was no recording on the body map and no accident report completed. The deputy manager agreed to look into this.

Where accidents and incidents had been recorded, this was done using a basic template. The template did not contain detailed information on any measures taken to control or prevent further occurrences or monitoring to ensure people were kept safe. There was no review of accidents or incidents to identify trends and not all accidents had been recorded. For example, one person's care notes referred to them pouring a hot drink over their back. We could find no record of an accident or incident report being completed for this event. No action had been taken to identify why this had happened or to prevent further occurrences. We could not be assured that the provider had appropriately identified the risks to people and taken all reasonable actions to mitigate any identified risks.

We looked at information the service held to support people in the event of emergency situations. Regular fire safety checks had been carried out and emergency drills had been practiced. A record had been made of who attended and the actions taken during these drills. We were shown a 'grab folder' containing information to be used in the event of an emergency. Personal emergency evacuation plans for 19 people were stored in this folder however, some had not been updated since 2012 and we were told plans had not been reviewed or drawn up for all the people living at the service. This meant staff had no guidance to follow in order to help them evacuate people safely should an emergency arise. The deputy manager agreed to review these plans and we saw they had been updated by the third day of the inspection.

A fire risk assessment had been completed in April 2015 and stated it should be reviewed in one year. We were told this had been carried out in April 2016. We saw the fire officer had visited to conduct training and a fire drill in April 2016 but evidence of the risk assessment being reviewed was not available.

The provider did not have a comprehensive contingency plan in place to ensure the safe continuation of the service in the event of an emergency such as loss of utilities, or severe staff shortage. There was a brief plan stating where alternative accommodation could be sourced and how staff could contact relevant organisations to arrange this. However, no other directions were available for staff with regard to such things as sourcing additional staffing or providing for loss of power or utilities.

In one person's room we found a rolled up, rubber backed mat. When we unfurled this we noted a very offensive odour and heavy staining. We asked what this was used for and were told it was no longer in use

but it had been placed next to a person's bed in case they were incontinent when they stood up. We requested this mat was disposed of immediately.

We saw a room marked with a sign 'Toilet'. This was used as a sluice room and a variety of cleaning equipment was stored in this room such as buckets and mops. Again we noted an offensive odour which appeared to be from the mop. We noted that there was a toilet in this room which had a broken seat that was leant against the wall leaving damaged hinges attached to the toilet. The room contained only one sink which was used for washing commodes and other equipment. There were no hand washing facilities in this room and there was no personal protective equipment readily available in this area. Furthermore the door to this room could not be closed fully.

In a room designated as a 'staff toilet' we saw there was no appropriate bin to dispose of sanitary wear. Instead this had been disposed of in an open waste bin with no bin liner. Furthermore the carpet cleaning equipment was stored in this room making the use of the facilities extremely difficult. We noted that the sinks in the sluice room and staff toilet did not have mixer taps. The water temperature was very hot and there were no signs to warn people of this danger.

Waste was not always dealt with appropriately. We saw a number of rooms did not have pedal bins and where there were pedal bins some had broken lids which did not function properly. None of the bins had liners to protect the interiors. On day two of the inspection we saw an open, unlined bucket containing clinical waste left on a landing unattended. There was a risk people may have been exposed to infectious materials.

The communal areas of the service were generally clean and tidy. However, carpets were marked in areas and items of furniture were heavily stained in some people's bedrooms, for example, armchairs. The vanity units surrounding the wash basins in people's rooms were in poor condition. The interiors of the units were badly water damaged and the vinyl coverings of shelves were peeling away. There were deposits of scale on a number of sinks, taps and toilets and we saw mould on the tiles in the wet room. Many sinks did not have plugs and one had the hot and cold tap indicators removed. In most rooms we saw paper signs written in ink stuck above the sinks with cello tape. They had been splashed with water and the writing was faded making them difficult to read.

Plastic light pulls in bathrooms were broken presenting a risk of injury. Equipment in people's rooms was not maintained adequately. For example, the covers on the seats of commodes were damaged and open exposing the inner foam. Many commodes were not robust and rattled when moved. Rust was evident on commode legs and the wheels were dirty causing difficulty in moving the equipment.

There was a store cupboard next to the wet room which staff referred to as the airing cupboard. The boiler was contained in this cupboard and it was very hot when we opened the door. We found bed sheets hanging over pieces of wood and the cupboard was generally dirty. A member of staff told us "We keep the bed sheets there to keep them warm." They told us they would remove the sheets and wood and have the cupboard cleaned. Many cupboards and wardrobes had large bags and items stored on top of them. This presented a risk to people as they could fall on them if they tried to pull them down.

There was a risk to people's safety when they were moving around the service. Many carpets were worn and frayed at joins, others were torn in places. Floorboards were loose in many rooms and corridors were narrow. We saw one corridor had been fitted with a handrail to guide and help steady people when walking. Four wheelchairs were placed along this wall which meant if people tried to use the rail they were likely to bump into the wheelchairs and could either fall or injure themselves. Some door handles were loose and ill-

fitting and in many rooms loose wires were draped from plug sockets over doorways and along skirting boards. They were not always contained in appropriate trunking and could present a risk if people caught their arms or legs in them.

The above constituted a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Maintenance of equipment such as the hoists, stair lifts, fire alarms and cooking appliances had been carried out by suitable contractors. Checks had been completed in accordance with current legislation and guidance.

People's medicines were managed safely. We observed the registered nurse administering medicines and saw they followed the provider's policy and procedure. Medicines were stored and disposed of safely in accordance with current guidelines and audits of medicines were conducted monthly by the service. In addition, a community pharmacist also carried out a full audit, the most recent was conducted on 9 June 2016. No major issues were raised at this audit but some actions were recommended. We saw the deputy manager had begun to address these during the inspection. For example, the protocols for medicine prescribed 'as required' had been reviewed and more current photographs of people using the service had been included on the administration records. Registered nurses attended refresher training and had their competency to administer medicines safely, checked.

There was a robust recruitment procedure. Checks were carried out on prospective employees including the completion of a Disclosure and Barring Service (DBS) check. A DBS check allows an employer to check if an applicant has any criminal convictions which would prevent them from working with vulnerable people. Other checks included seeking references from past employers with regard to an applicant's previous performance and behaviour. A full employment history was requested from all applicants and gaps in employment had been explored and explained. Professional registers such as those held by the Nursing and Midwifery Council were checked to ensure staff had current registration to practice. When agency staff were used, a record of their recruitment checks and training were kept at the service. However, we reviewed the record for the agency staff currently used at the service and found the record was out of date. The deputy manager contacted the agency immediately and an updated record was in place by the second day of the inspection.

There were mixed responses when we asked about staffing levels. Some staff thought there were enough of them to meet people's needs while others had doubts. One member of staff said, "I am hands on and have a lot of physical clinical work to do and I don't always have the time to do the paperwork. I always give priority to my clinical work." Another staff member said, "I like working here because I care for people. Sometimes it can get too much, especially when we are short and can't get anybody." We saw the registered manager and deputy manager spent much of their time working 'hands on'. This meant they did not always have sufficient time to complete the managerial duties of their role.

There was no formal tool used to determine the staffing levels required although we were told this was assessed according to the dependency and needs of people living at the service. The service had a determined staffing level for each shift which was maintained. We were told additional staff were allocated if a person had increased needs. For example, when a person required end of life care or one to one support to manage behaviour that may cause harm to themselves or others. Throughout the inspection we observed people received prompt care.

Requires Improvement

Is the service effective?

Our findings

People did not always receive effective care and support. 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. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals 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.

Staff had received training in the MCA and DoLS but some found it difficult to explain to us how it related to their work. However, we did observe staff seeking people's consent before doing anything for or with them and checking people were happy with what they did for them. We also observed staff offering people choices in everyday decisions such as what they wanted to do or what they wanted to eat.

The registered manager told us some people had decisions made for them by relatives who had Lasting Power of Attorney (LPA). Although some people's records stated a relative had this authority they did not confirm whether the LPA was for making decisions with regard to health and welfare, financial decisions or both. There was no recorded verification of the LPAs and we could therefore not be assured that decisions were being made on behalf of people by those properly authorised to do so.

Providers are required to submit applications to a 'supervisory body' for authority to restrict people's liberty. At the time of the inspection we saw records stated 18 people had a DoLS authorisation in place. One file we reviewed indicated an authorisation was in place but we found although an application for DoLS had been made over a year previously an authorisation had not yet been granted. There was a tracking form in the file, but it had not been used effectively and it was not clear if the application had been chased up. Staff told us, assessors from the local authority had assessed the person a few weeks ago and "it's recorded somewhere". They were not able to locate a record of this and no authorisation was on the file. As an authorisation had not been received from the 'supervisory body' there was potential for this person's freedom to be restricted unlawfully. We noted the care plan for this person stated they had DoLS in place and should they die the coroner must be informed. When we asked why this had been put on the file before an authorisation was in place, we were not given a satisfactory answer. However, we did see other people had DoLS authorisations in place which were being monitored effectively to ensure they were reviewed as required by the 'supervisory body'.

The design of the premises did not always meet people's individual needs. A relative commented on the lack of space to have some privacy with their family member. They told us there was nowhere they could go to enjoy time together and listen to music or talk. This was because the effort to go up and down the stairs or use the stair lift would be too exhausting for their family member. They felt this had a negative impact on the quality of the time they spent together.

People shared bedrooms so there was a lack opportunity for them to spend time alone or have some private time with their visitors if they wished to. There were no alternative areas for people to use for these purposes. A stair lift was in place to enable people to reach other levels of the service. However, for some people this meant they needed to move from one stair lift to another twice or three times to reach their room on the top floor. One relative found this particularly distressing and expressed concern for people using the service, staff and visitors. This may also have inhibited people from spending time in their rooms. We saw that many people stayed on the ground floor throughout the day unless they were nursed in their bedrooms. It was not clear if this was their choice or that they found it too tiring or difficult to go back to their rooms.

The décor of the home was in poor condition. We saw paintwork had been repeatedly painted over and had chipped away on a number of surfaces. Carpets were stained and damaged in areas and some rooms were in need of redecoration. The staff had hung photographs of special events throughout the ground floor depicting people enjoying themselves and sharing time together. There were also some decorative pictures in the hallway and communal areas of the service. However, there were no specific adaptations such as coloured doors or memory boxes to aid people living with dementia.

This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The majority of activities including eating and drinking took place in the main lounge. There was a smaller 'quiet' lounge available, however we saw the door was kept open throughout the inspection and it was not clear if people were able to spend time in a quiet area away from the main activities. Some people enjoyed the outdoor space provided by a safe and secure garden area. We were told some new garden furniture had been recently purchased via a legacy left to the service and we saw people making use of this and enjoying the area.

Staff had an induction when they began work at the home and spent time working alongside experienced members of staff. They then went on to complete the care certificate. The registered manager and the deputy manager had attended training on the care certificate standards and were responsible for assessing staff on their knowledge and competence.

Staff told us they had received sufficient training to feel confident. They said the registered manager ensured they received refresher training when it was due and they could ask for additional training if necessary. However, we reviewed the training records and found not all training was up to date. For example, two registered nurses, one cleaner and two care staff had no record of moving and handling training and a further staff member's training was out of date in this area. Eight staff members had no fire training recorded and one registered nurse and 16 staff had not received training in infection control including two staff employed as cleaners.

We looked at the training certificates and saw they did not always state the content of the training course and the topics covered. For example, we could not always establish if practical moving and handling training had been undertaken or if it was purely theoretical. Evidence of knowledge and competency was not available for all staff.

We observed staff prepare to use an inappropriate method to reposition a person. It was only when another member of staff intervened the correct method was used. This indicated that staff had either not received or understood the moving and handling training. In addition, despite all staff telling us they had received safeguarding training some staff were not able to tell us what safeguarding was, what signs might indicate

people were being abused or what they would do about it. The maintenance worker was also responsible for carrying out the testing of portable electrical appliances and ensuring checks were carried out on bed rails. However, they stated they had not received training in either of these areas. Additionally, the deputy manager told us they were responsible for carrying out risk assessments but had not had training in doing so.

This was breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Training in areas relating to people's specific needs was available, for example, dementia awareness and staff had been given the opportunity to gain recognised qualifications such as National Vocational Qualifications and diplomas in health and social care. Staff said they felt supported by the senior staff and registered manager and they could seek advice and guidance at any time. Staff received an appraisal of their work annually and we saw these had been recorded.

The registered manager told us that regular one to one meetings took place between staff members and their manager at least quarterly. We reviewed the records and saw meetings were recorded on a supervision matrix but not always on individual staff files. The purpose of these meetings was to support staff and provide an opportunity to discuss their development and any issues or concerns that may have arisen in connection to their work. Staff told us they felt supported by the managers and had opportunities to discuss their work with them.

People told us the food was good and they enjoyed it. One person said, "The food is very good." At lunchtime we observed people being supported to eat. People ate in a variety of places, some were supported in the lounge, others in the dining room or their own rooms. Staff supported one person at a time and sat next to them in order to engage with them. People were encouraged to eat independently if possible. If staff observed people were leaving their food they gave prompts and assistance to try to ensure they received adequate nutrition and hydration. If people did not want to finish their meal supplements and snacks were available and encouraged.

People appeared relaxed at meal times. In the dining room we saw people talking around the table in a sociable manner enjoying each other's company. They discussed a forthcoming trip to the seaside and were looking forward to having fish and chips on the beach. We spoke with one of the catering staff who explained how they cater for individual diets such as gluten free or diabetic. They told us menus were prepared based on people's preferences and there was always a choice if people did not want to eat what was on the main menu. We saw people were offered choice, for example, one person did not want the meal from the main menu at tea time on the first day of the inspection. They were asked what they wanted and their choice was prepared for them which they said they enjoyed very much.

People's weight was recorded monthly or weekly if they were at risk of malnutrition. A recognised tool was used to monitor people's risk and this was reviewed monthly. When necessary, people had been referred to the Speech and Language Therapist (SALT) for assessments in connection with difficulty in swallowing.

People's healthcare needs were met and they were able to see healthcare professionals when they required. The GP visited the home twice weekly and staff could request visits at other times if necessary. We received feedback from two healthcare professionals who felt people's health needs were well supported and met by the service. Referrals had been made to specialist health care professionals for example, mental health professionals when necessary. People had also seen dentists, opticians and chiropodists regularly.

Requires Improvement

Is the service caring?

Our findings

People's privacy and dignity was not always preserved. Most bedrooms at Haldane House are shared by two people. We saw curtains were used in rooms to separate areas for individual people to receive care and support in private. However, in one room there was no curtain in place to provide this privacy. We raised this with the deputy manager and were told that one person using the room had pulled it down. This meant there was no means to provide privacy in this room. Furthermore, when we looked at the ensuite bathroom in this bedroom we saw it was used to store an oversized bean bag which prevented the facilities being used. We could therefore not be assured that the two people sharing this room were provided with privacy and dignity.

In another shared bedroom we found a locked storeroom. This was used to store equipment such as mattresses, bed rails and pillows. Some of the equipment stored such as the pillows were old and stained and were not fit for purpose. However, the use of the room may impact on the privacy and safety of the people using the bedroom. If staff needed to access the equipment they would have to enter people's private room and therefore may disturb them by having to move things.

One bedroom had two doors, one of which led to the back staircase. We saw this room was used as a walkway to the backstairs by staff to take dirty linen to the laundry room. When we raised this, we were told it was used like this to avoid taking dirty linen through the main hallway and potentially meeting visitors. We were also told staff did not use it for this purpose when the people using the service were in it. However, this did not respect people's right to privacy and dignity.

On the first day of the inspection we saw one person had a transdermal patch changed while sitting in the lounge. This involved the person having to move some clothing to reveal the upper part of their arm. They were not offered the choice of going to their bedroom for this to be done or the option to be screened from others while the procedure took place. Another person had tubigrip removed from their legs and medicated gel applied while sitting in the lounge area with no screening from other people. Again they were not offered the option of moving to a more private area for this to be done.

We looked at the facilities in the main bathroom on the ground floor. We saw charts were on display listing all the names of people using the service and recorded if they had opened their bowels and when they had last used the toilet. This information was available to anyone who entered the bathroom. We also found a cupboard containing nightdresses. We asked who they belonged to and were told they were used for anyone and were kept there in case someone had 'an accident'. Staff could not explain why people's own clothes were not brought from their room in such a case.

In the same bathroom we saw plastic baskets containing items such as hairbrushes, combs spectacles and toothpaste. Some were labelled with people's names but others had no labels at all or the labels were damaged. We were told each person had their own basket for personal items used in the bathroom. However, staff could not assure us people only used their own items. We saw baskets with belts, combs and hairbrushes full of hair which staff could not identify as belonging to particular people. This indicated they

were used for a number of people. We raised this with the deputy manager and action was taken to deal with it straight away. By day three of the inspection all baskets had been labelled and individual items were appropriately stored.

People were not always referred to with respect in the records we reviewed. There were examples of inappropriate language used, for example, people were referred to as 'wanderers' on a list hung on the dining room noticeboard stating staff should check their whereabouts on a regular basis. In other records people were referred to as 'verbally aggressive' or 'noisy'.

This was breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and relatives we spoke with praised the staff. One person said, "It's like home, the nurses are lovely." Another told us "they will do anything for me if I ask them". A relative described how their family member had been confined to bed when they first came to Haldane House. They told us staff had worked very hard with their relative to regain mobility which had had a positive impact on their life and independence.

We saw people approach staff and receive polite and caring responses. People appeared relaxed in the company of staff and we heard friendly conversations and observed positive interactions throughout the inspection. We heard jokes being made between people and the staff and it was evident people enjoyed this humour by their smiles and replies.

Staff responded and spoke to people in a polite manner. We saw staff position themselves to ensure they were speaking to people at eye level. For example, one care staff sat on a low stool in front of a person so they could see their face and lips when they spoke to them. People told us staff addressed them using their preferred name.

Staff knew most people living at the service well. They told us they had got to know them over a period of time and knew what people liked to do and their individual care needs. They told us they were aware of people's past history and interests which helped them to understand and engage with people.

People had brought favourite things from home with them when they moved into the service. Family photographs and items relating to past hobbies and careers were evident in people's rooms. People were encouraged to continue with hobbies if they wished to, for example we saw one person crocheting a blanket while others who could no longer actively engage in their hobbies were encouraged to talk about favourite things such as sport.

People told us they were consulted about their care and they felt they were listened to by the staff. Staff encouraged people to be independent whenever possible.

Requires Improvement

Is the service responsive?

Our findings

The registered manager told us people's needs were assessed before they moved into the service and a care plan was then developed using this information. They told us this was reviewed regularly and adjusted as staff got to know them and they settled into their new environment. We reviewed the file of a person who had recently moved into the service and saw there was little detail recorded on the pre-admission assessment to assist in the formulation of a detailed personalised care plan. For example, under mobility it stated 'uses rotunda to transfer, walks with a frame' there were no details relating to the support required by the person to stand, sit or move in bed. In another section designed to record an assessment of behaviour that may cause distress or anxiety to the person or others, the assessment simply read 'yes' while under nutrition it said 'thickened fluids, SALT involved'. There was no record of the person's personal preferences being discussed.

At the time we reviewed this person's file they had been resident at the service for nine days but no care plan had been written. We also reviewed the file for a person who had been living at the service for 15 days and again found no care plan had been completed. This meant staff had no clear guidance as to how to respond to this person's needs. Therefore there was a risk people would receive inappropriate care.

Other care plans we reviewed contained more detailed information and included some personal preferences and choices. These included preferred times to get up and go to bed, particular food likes and dislikes as well as hobbies and interests. They also contained guidance for staff to follow when responding to people's needs.

We found that care and support was not always provided in a person centred or individualised way. The service did not have a system to provide opportunities for staff to acquire a more in-depth knowledge of people they supported on an individual basis. The allocation of work to the care team was generally done by floor or task and we heard examples of staff referring to tasks such as 'doing the toileting' and 'doing the feeding'. This meant that people did not receive care that was individualised to their own needs at a time they needed it.

This was breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us they were kept up to date with any changes to care plans or people's well-being through handover meetings. Verbal handovers took place at the beginning of each shift. We observed a handover on the second day of the inspection and saw each person was spoken about individually. Staff who were coming on shift were able to ask questions and check they had the most up to date information. Notes were made on each person in their care file and a new electronic recording system had recently been introduced. We saw staff recorded detail of such things as people's dietary intake, the personal care they had received and when necessary any repositioning or checking of people's whereabouts. As this was a new system staff were unsure of its effectiveness and continued to also record the same detail on paper records.

A programme of activities was provided and included reminiscence sessions, games, quizzes, music for health and crafts. In addition, visits from animals, trips into the local community and days out were organised at various times throughout the year. Social gatherings to which relatives and friends were invited were also organised and relatives told us these were greatly enjoyed and appreciated. At the time of the inspection people were looking forward to one such event to celebrate the Queen's birthday. There were no specific activity staff but the care staff organised and supported people with the activities during the afternoons. There were some individual activities conducted with people such as manicures or simply sitting and chatting with people if that is what they wanted. Where people were unable to leave their room staff spent some time with them on a one to one basis.

We observed activities on the first day of the inspection. Some people joined in with a music quiz, others just enjoyed the music. Manicures were offered to people and some people saw the hairdresser. One person had recently come out of hospital and had requested their hair to be styled as in an earlier photograph of themselves. This was completed and afterwards they appeared to be very pleased with the result.

The provider had a complaints policy and procedure. People and their relatives told us they were aware of how to raise concerns and complaints. People said they could go the registered manager or the deputy manager if they had any concerns and felt they were always available to listen to them. The service had not received a complaint since the last inspection but had recorded two concerns relating to clothing and spectacles which had been dealt with promptly. The deputy manager felt there were no complaints because they listened to any 'little concerns' and addressed them 'straight away'.

There were no formal meetings arranged for people or their relatives to provide feedback on the service. However, the deputy manager told us there was always an open door to the registered or deputy managers. Relatives confirmed this and said they were also encouraged to give feedback via a quality survey.

Requires Improvement

Is the service well-led?

Our findings

There was a registered manager in post at the time of our inspection and they were present for part of the first day of the inspection before they left to go on leave. For the remainder of the inspection we were assisted by the deputy manager and the general manager.

Staff spoke highly of the registered manager and deputy manager and told us they were approachable and supportive. They said they could speak to them at any time and the "office door was always open". They also commented on how they helped out with providing care for people and said they valued this support. However one commented, "I feel sorry for the nurses (this includes the registered manager and deputy manager) they are very good and helpful and very keen to teach but they don't always have the time".

Staff told us they could make suggestions for improvements but they were not always acted upon by the provider and suggested there was not enough money to make significant changes. Many of the staff team had been dedicated to the service for a long period of time and told us they enjoyed working there.

Staff meetings were held and recorded. We reviewed the minutes of the last meeting held in March 2016. Attendance at staff meetings was not always good and we saw only 12 staff attended this meeting. This was raised at the meeting and the minutes noted that all staff were expected to attend. We were told all staff received a copy of the minutes to ensure they were kept up to date. Staff told us these meetings provided an opportunity to discuss improvements to the service. We saw the minutes noted suggestions such as the need for more internal signage. However, we did not see evidence of these improvements having been made during the inspection. A member of staff told us there was an on-going programme to replace equipment however they said they had been waiting for a new bath to be fitted for over a year. We were told some beds had been replaced but everything had to be "prioritised".

There was no clear system in place for ensuring staff had the skills and knowledge to meet people's needs. We were shown a hand written training matrix for 2016. This detailed only the training that had been completed since January this year. We could not identify from this if all staff had up to date training considered mandatory by the provider. We then reviewed a similar matrix for 2015 and by comparing them found that some training had not been provided at all and other staff required refresher training. This system of recording had no provision for alerting the registered manager as to when training was required.

People's care plans and daily records had not been audited since January 2015. We saw that some care plans had been written in 2008 and although the records indicated they have been reviewed monthly, most entries read, "care plan remains current". When changes had occurred they were noted in the review but not onto the main care plan document making it very difficult to find the most current and up to date information. There were also examples of risk assessments not being reviewed for long periods of time. For example, one person's falls risk assessment was last reviewed in December 2015 and in another case a person's moving and handling risk assessment had not been reviewed since March 2015. As regular auditing had not taken place these issues had not been identified.

Other audits were carried out such as infection control, moving and handling equipment, air mattresses, health and safety and medicines. However we saw that some audits had the same issues highlighted over a number of months and it was not clear what action had been taken to rectify matters or escalate the issues. For example, the infection control audit noted buckets and mops to be kept clean on three audits before it was no longer noted. There was nothing to suggest what action had been taken to deal with this or if the issues had been dealt with.

Routine maintenance of the service was carried out by a maintenance worker. The maintenance worker also carried out health and safety checks on some equipment and conducted an audit each month to identify areas of the service that required attention. For example, they checked carpets, condition of rooms and furniture. However, these audits had not identified the issues we found during the inspection.

A report was sent each month to the provider's head office which included such things as new admissions, deaths or discharges, staff leave and sickness and audits conducted. We saw on the June report all the sections relating to audits including care plans had been ticked as being completed. However, we could find no evidence of care plans being audited since January 2015. There was no evidence of these reports being followed up or checked for accuracy by the provider.

These examples constituted a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A quality survey was conducted to gather feedback from relatives. The most recent survey in March 2016 attracted nine responses which were mainly positive. Comments included, "The care my mother gets is excellent from all the staff." "Kind and considerate all treated with the utmost care and dignity." The results of the survey had not been fully analysed but we were told this would be done and a report produced and shared with people and their relatives. We saw a report had been produced and circulated the previous year.

The service was not meeting its registration requirements in terms of statutory notifications sent to the Care Quality Commission (CQC). Notifications regarding the authorisation of Deprivation of Liberty Safeguards had not been submitted. The registered manager told us there had been a misunderstanding with the local authority about who should inform CQC. They agreed to forward these retrospectively after the inspection. Other notifications had been submitted promptly.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care People were at risk of not receiving person centred care because the registered person had not always carried out an assessment to ensure the care and met their needs and preferences. Regulation 9 (1) (b) (c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The registered person had not made suitable arrangements to ensure that people were provided with privacy and treated with dignity and respect. Regulation 10 (1) (2) (a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The registered person had not ensured there was an effective system in place to assess, monitor and improve the quality of service provided. Regulation 17 (1) (2) (a)

Regulated activity	Regulation
Accommodation for persons who require nursing or	Regulation 18 HSCA RA Regulations 2014 Staffing

personal care

Treatment of disease, disorder or injury

Staff did not receive such appropriate support, training, professional development and supervision as is necessary to enable them to carry out the duties they are employed to perform.

Regulation 18 (2) (a)

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered person had not ensured risks to people's health and safety had been assessed or action taken to mitigate such risks. Regulation 12 (1) (2) (a)

The enforcement action we took:

A warning notice was issued

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 15 HSCA RA Regulations 2014 Premises and equipment People who use services and others were not protected against the risks associated with unsafe or unsuitable premises. The registered person had not ensured the premises and equipment used were clean and suitable for the purpose for which they were used. Regulation 15 (1) (a) (c).

The enforcement action we took:

A warning notice was issued