Haisthorpe House Care Limited

# Haisthorpe House

**Inspection report**

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## Ratings

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|---|---|
| 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

The overall rating for this provider is 'Inadequate'. We have cancelled the providers registration.

This inspection took place on 17 and 22 June 2015 and was unannounced.

At our last inspection of Haisthorpe House in February 2015 we found that people were not always treated in a respectful manner and were not always receiving safe, consistent care and support. We also identified that the provider had not complied with the law with regard to the Mental Capacity Act 2005 and the Deprivation of Liberty safeguards. We found people were not protected against the risks of being harmed by other people and nor were people protected from the risks of unsafe management of medicines. Furthermore we determined the home was dirty and uncared for and maintenance work needed to be done to the building in order to protect the health and safety of the people living, working and visiting Haisthorpe House. We found there were not always enough staff working, and those staff were inadequately trained and supported. Recruitment processes needed to improve to ensure that only suitably vetted people were employed to work at the service. Records were poorly completed and people were not supported to make complaints. We saw the registered provider did not have

# Summary of findings

arrangements in place to monitor how the service was operating. This meant that no-one had identified that the service delivery was not good enough and therefore needed to improve.

Because we had significant concerns about people's welfare and safety we took enforcement action against the provider.

At a previous inspection in July 2014 we had issued three warning notices and nine compliance actions to the registered provider and told them that they must make improvements. We also required the registered provider to submit regular updates to us to demonstrate the improvements being made. Furthermore the registered provider had agreed to not admit any more people to the home, until the improvements had been made.

This inspection was to check whether progress had been made as recorded in the registered provider's action plan. The provider had told us within their action plan that they would have an overall date of compliance of March 2015. There were also a number of key areas which the provider told us they would address prior to this date. As we identified a range of areas where improvements were required at our last inspection, we carried out another comprehensive inspection at this visit, looking at all aspects of the service delivery.

Haisthorpe House has been registered by Haisthorpe House Care Limited to provide personal care and accommodation for up to 30 people with a mental health illness and/or a learning disability. The home is a large detached mature house, located on Holgate Road within about 20 minutes walking distance from the centre of York. There are local amenities close by and the service is on a public bus route. There is very limited parking on site and nearby on-street parking is also quite limited.

On the day of our visit there were 22 people living at Haisthorpe House. There was no registered manager of Haisthorpe House. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. Although a manager had been employed at the service for approximately five weeks they had not yet applied to be registered.

We found overall that there was insufficient evidence to demonstrate that the required improvements had been made.

We found the risk of harm to people was not well managed. People were not protected from incidents of abusive behaviour and these incidents were not reported to the right professionals. This meant no-one had the opportunity to look into these events and decide how best to minimise the risk of a similar incident happening again.

We found the risk of harm to people overall was not well managed. When staff recognised people were at risk, then this risk was not kept under review, to check whether the service was doing all it could to keep people safe. This meant people may be being exposed to a risk that could be avoidable.

We found that the environment was not well maintained. We found bedrooms without window restrictors and other windows which did not open, meaning there was insufficient ventilation and. Safety checks, completed by staff on the environment did not result in the required works being completed. This posed a risk to people living and working at the home. The fire safety risk management measures at the service were poor. Many of the people living at Haisthorpe House smoked and not all had safe smoking habits. This increased the risk of a fire breaking out. Checks to minimise these risks were not always being completed. We also found rooms which were in a poor state of décor and repair.

Generally people told us that staffing numbers were sufficient, although the home was relying on agency staff to ensure sufficient numbers of staff on duty. Appropriate checks were completed before new staff started work. These checks were needed to ensure that there was nothing in an applicant's background that would make them unsuitable to work with vulnerable people.

Medicines were not always managed safely for people and records had not been completed correctly. People did not receive their medicines at the times they needed them and in a safe way. Medicines were not obtained, administered and recorded properly.

Despite a domestic now being in post we found some areas of the home were dirty and needed more frequent cleaning.

# Summary of findings

The staff team had a better understanding of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) than in our last visit. They also had a better understanding of their responsibilities of supporting people who were being cared for in the community under an order of the Mental Health Act 1983 Code of Practice (MHA). However, they still needed to evidence that they were consulting people regarding all aspects of their care and they needed to make sure that people were given sufficient opportunity in making decisions and choices.

Whilst people told us they enjoyed the meals served to them at Haisthorpe House the service 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 well-being.

People's changing healthcare needs were not always known and understood. This meant people could be at risk of harm because the service failed to respond promptly and appropriately to a new care need.

We observed staff who were kind and caring in their approach to people. People told us they liked the staff who cared for them. However, some people looked unkempt during our visit and we found that some people were not being appropriately supported in terms of their personal care needs.

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

People's care records were of varying quality, however some did not contain the required information and others were not being appropriately followed. Not all staff had been given the opportunity to read care plans which meant they may not know how to care for someone appropriately.

People now had a copy of the complaints procedure and people told us they would feel confident in speaking to staff if they had a complaint or concern.

The service was poorly led, with a lack of management support in the home. Day to day communication about people's needs was ineffective, which meant people's changing needs may be missed or not known.

We noted care records did not provide good quality information about people's needs, or their preferences and choices. They were not updated when people's needs changed. The checks on how the service was being run were also ineffective as recent checks had indicated that service delivery was satisfactory.

There was a lack of consultation with people living at Haisthorpe House about their care and how the service was operating. This showed a lack of respect towards the people living there and failed to value their contribution to how the service was being run.

We found the registered provider was in breach of nine regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3). These were in relation to safeguarding service users from abuse and improper treatment, safe care and treatment, premises and equipment, staffing, need for consent, meeting nutritional needs, person centred care, dignity and respect and good governance.

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

# Summary of findings

## The five questions we ask about services and what we found

We always ask the following five questions of services.

**Is the service safe?**

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 Haisthorpe House.

The overall risk of harm to people was not well managed and was not kept under close review.

People were not protected against the risks associated with the use and management of medicines. Whilst we saw some improvements since our last visit, there were still some issues which meant that people did not receive their medicines at the times they needed them and in a safe way. Medicines were not obtained, administered and recorded properly.

**Is the service effective?**

Inadequate

The service was not effective.

The induction, training and supervision of staff was still not providing them with the right skills to care for people safely.

There were ineffective systems in place to ensure people's changing healthcare needs were known and understood.

**Is the service caring?**

Inadequate

The service was not caring.

Whilst staff were kind and friendly they lacked the leadership they needed to support people appropriately and to promote people's independence and self-worth.

People's privacy and dignity needs were not always being addressed. In some cases we found people's personal care needs were neglected.

**Is the service responsive?**

Inadequate

The service was not responsive.

People were not receiving a person-centred service. Care records were of varying quality and staff were not following the guidance in care plans, which meant people may not be cared for appropriately.

**Is the service well-led?**

Inadequate

The service was not well led.

The service lacked leadership and appropriate support. Checks to ensure the safety of the premises and to reduce risks to people were not actioned where concerns were identified, which meant the staff could not provide safe and appropriate care to people.

# Haisthorpe House

**Detailed findings**

## Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the registered provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 17 and 22 June 2015 and was unannounced. On the 17 June the inspection team comprised five people. These were two adult social care inspectors, an inspection manager, one pharmacist inspector employed by the Care Quality Commission (CQC) and the fifth person was a specialist professional advisor. This was an expert with a mental health background and was an Approved Mental Health Professional (AMHP). On the 22 June the visit was completed by an inspector and an inspection manager.

Prior to the inspection we reviewed the information we held about the service, such as information about incidents that happened at the service, which the registered provider has to inform us about and information shared with us by other agencies. We received information from professionals who regularly visited people who lived at Haisthorpe House and from the City of York commissioning team who had been carrying out their own monitoring visits to the service in recent months.

We also looked at other records about the service kept by CQC, including documents that the registered provider was required to send to us each month to demonstrate how the service delivery was being monitored and improved.

We did not request a Provider Information Return (PIR) as this was an inspection to check whether failings, found at the last inspections in February 2015 and July 2014, had been addressed.

At the inspection we talked to nine people using the service and eight care staff and a domestic who was subcontracted to work at the home.

We looked at the care records for seven people and observed the way staff interacted with people. We also looked at a number of other records including medication assessment records, fire safety records, and other audits of how the service was operating. We looked at the overall environment and how well it was being maintained, including looking in many of the bedrooms. We looked at five staff recruitment files and training records.

Inadequate

# Is the service safe?

## Our findings

At our last inspection in February 2015 we found the registered provider was not ensuring people's safety by making sure the risks of harm from abuse were being properly managed. We found continued concerns which we had also identified in August 2014. People told us they did not know who they would tell if someone hurt or upset them. Incidents were not being appropriately reported and followed up with the local authority safeguarding team, who take the lead in investigating these concerns. Staff had not received appropriate training and they were unaware of the reporting procedures should an area of suspected abuse be identified. We also identified a number of medication failures during the inspection, where people had not been given their medication as prescribed. The service had not recognised these 'failings' and subsequently had not made the appropriate safeguarding vulnerable adults alerts.

During this inspection we found that people were still not protected from the risk of abuse. Example's included; incident forms where risks to people had been identified but no action had been taken. For example, one person was described with a burst blister to their forehead and bruising. There were no concerns or issues recorded on the incident report. The section for 'has it been recorded' was blank. There was no evidence of follow up or action to investigate why the bruising had occurred. Another example included an incident where an individual had hit another individual with a stick. Again there was no evidence that this had been reported or any action had been taken.

We saw a number of incident reports, some where the police had been called as people had gone missing, or others where there had been an altercation between people living at the home. We saw that the section for 'have all appropriate referrals been made' had not been completed.

We also saw an incident where an individual had been aggressive to a member of staff. There was no incident form completed.

**Our findings demonstrated a continued breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3).**

At our last inspection in February 2015 we found that risks to people were not being appropriately managed. For example, staff were unclear of the emergency arrangements to follow when working out of hours. They were unclear of whistle blowing procedures and how they could escalate concerns to the provider. We also identified concerns around the way fire safety risks were being managed. This was particularly evident in relation to smoking risks. Records to demonstrate that appropriate checks were carried out to minimise these risks were poorly completed.

During this inspection we found that risks were still not being appropriately managed. For example, we found that an individual with diabetes was put at significant risk due to the lack of actions by staff to respond to a drop in blood sugar levels. We found that guidance records in care plans were not being followed and insufficient advice and support from professionals was being sought. We referred this matter to the local safeguarding team after our inspection

We saw one risk assessment which recorded that an individual was at high risk of personal injury due to self-harm, that the frequency was likely, the severity high, and the risk level high, yet it also stated that the last incident was in 2006. If this individual remains at high risk there should be more up to date documentation to support this and the care plan would need to reflect this also.

We also found that appropriate checks for example; checks to see if people were smoking or checks to monitor people's blood sugars were still not being carried out as stated in individual risk assessments and care plans. This meant there was a lack of robust management of the risk of harm to people which meant people's care and support needs were still not being safely met. In addition we saw in two people's care files numerous recorded incidents of them smoking in their bedroom. These were not followed up with incident reports.

**Our findings demonstrated a continued breach of Regulation 12 (2)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3).**

At our last inspection in February 2015 we found some aspects of the building were poorly maintained, which placed people living and working there at risk of harm. Examples included a chimney stack which was unsafe and

# Is the service safe?

at risk of toppling in windy conditions. A lack of suitable smoking facilities, a lack of window restrictors and poor standards of maintenance and repair throughout the building.

During this inspection we found that the smell of cigarette smoke was less apparent than during previous visits to the home. The registered provider had implemented a 'no smoking' policy throughout the home and people were being encouraged to smoke in a designated area outside. However, some people were still smoking in their rooms and we saw three carpets with cigarette burns in them. For these people, the smoking checks completed by staff were paramount and we found that these were not always being completed as recorded in their care plan. This meant that their may be an increased risk of fire at the service. We shared this with the manager who reviewed and updated the risk assessments so that those people who required regular checks received them.

We looked at a number of people's bedrooms. We found nine bedroom windows which did not have appropriate window restrictors in place. This meant that some windows could be opened wide; others had a wooden block which meant in some cases the window could not be opened at all so people may not have sufficient ventilation. In other cases the wooden block had split. This meant the service was not ensuring the safety of people living there, and particularly those people who may be at risk of self-harm. The window restrictor checks completed on the 23 May 2015 recorded no changes from 10 May 2015. This meant that despite staff recording that windows were not restricted, were painted shut or were not working properly appropriate action had not being taken.

We saw a number of rooms were poorly maintained. Although some rooms had been decorated others had not. Some rooms still had stained walls, stained carpets and were poorly maintained.

A programme of redecoration and refurbishment was on-going.

We found a gas safety report dated 3 April 2015 which stated "Loft boiler requires proper access, ladder and working platform. This is a regulation and requires fixing as soon as possible." This had not been done. We saw a water services report dated 28 May 2015 which identified a number of failed valves which had not been replaced. We also saw a food safety report dated 20 April 2015 which had not been actioned.

In addition, although the home was carrying out health and safety checks on the environment, they were not always taking sufficient action. For example, water temperature checks were being completed. Where water temperatures had been recorded as too high staff had recorded 'manager aware'. There was nothing else recorded to demonstrate that any action had been taken to address this.

We looked at the health and safety report dated 6 October 2014. This identified a number of issues which were colour coded red, amber or green dependent on the level of risk. We saw that some areas recorded as high risk had not been addressed. For example windows were not fitted with safety glass, the response recorded was 'maintenance' and no action had been taken to address this issues.

We looked at the fire door weekly checks dated 20 June 2015 three doors were recorded as 'sticking requires attention', yet on our visit on the 22 June no action had been taken to rectify this. We shared this with the manager who arranged for a contractor to address the issues on the 23 June. We also found that fire room checks were being completed but without the frequency recorded in people's care files.

We spoke with people regarding the changes to the environment. One person said that their bedroom had been repainted and they were pleased as they had been able to choose the colour. Another person said that they were not sure when their room was being decorated but did confirm that they had been involved in choosing colours. Both people told us that they felt the home had improved over recent weeks due to the redecoration taking place.

However despite people's positive comments our observations made during both days of our visit identified significant concerns in relation to the environment. Due to the seriousness of our concerns we asked the provider to take the necessary action to address the health and safety issues. As some of the work involved required the involvement of specialist contractors we asked the registered provider to write to us to confirm when this work had been completed.

Inadequate

# Is the service safe?

**Our findings demonstrated a continued significant and serious breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3).**

We looked at staff rotas during this inspection and talked to staff about staffing levels. On day one of our visit there were six staff on duty, two of whom were agency staff. There was also a domestic and the new manager. On the second day of our visit there were five staff, a domestic and a manager on duty. Staff told us that staffing levels were sufficient to care for people although they did say that domestic staffing hours needed to increase.

At our last inspection in February 2015 we found the service did not ensure robust recruitment checks were completed before new staff were employed. These checks were needed to ensure the applicant was suitable to work with vulnerable people. We told the provider to improve this area of service delivery. At this inspection, we looked at the recruitment files for five members of staff. Some of these staff were working at the service when we last inspected, in February 2014. We found appropriate recruitment records were in place for all of these individuals.

At our last inspection in February 2015 we found significant concerns about the way medication kept at Haisthorpe House was being managed. We found instances where people were not getting their medication as prescribed and the service did not have safe systems to ensure people received their medication appropriately. We told the provider to improve this area of service delivery.

At this visit we asked if medicines were handled safely. We looked at the medicine administration records for 13 people, talked to staff and people living in the home.

Medicines were not obtained, administered and recorded properly. Whilst we saw some improvements since our last visit, there were still some issues which meant that people did not receive their medicines at the times they needed them and in a safe way.

We saw a senior carer giving people their medicines. They followed safe practices and treated people respectfully. We were told that one person looked after some of their medication themselves. However, we saw that risk assessments were not completed. Without the assessment the registered provider could not ensure that the individual knew when and how to use their medication and could use it safely.

Two prescribed nutritional supplements for one person were not available. This meant that the arrangement for ordering and obtaining people's prescribed medicines was failing, which increased the risk of harm.

We looked at the guidance information kept about medicines to be administered 'when required'. Although there were arrangements for recording this information in the individual care plans we found this was not kept up to date and information was missing for some medicines. This meant there was a risk that staff did not have enough information about what medicines were prescribed for and how to safely administer them.

Medicines were not handled safely. Records relating to medication were not completed correctly placing people at risk of medication errors. If the dose had been omitted staff had not recorded the reason for this. The records which confirmed the application of creams and other topical preparations were incomplete. Incomplete record keeping meant we were not able to confirm that these medicines had been used as prescribed.

When we checked a sample of 'boxed' medicines alongside the records we found that for eight out of nine medicines checked, more of the medicine remained than the administration records indicated so we could not be sure if people had them administered correctly.

Medicines were kept securely in locked cupboards. Records were kept of room temperature and fridge temperature to ensure they were safely kept. Medicines that were liable to misuse, called controlled drugs, were stored appropriately. Additional records were kept of the usage of controlled drugs so as to readily detect any loss.

We looked at how medicines were monitored and checked by managers to make sure they were being handled properly and that systems were safe. We found that whilst the home had completed a medicine audit recently it was not robust and had not identified all of the issues found during our visit.

**Our findings demonstrated a significant and continued breach of Regulation 12(2)(f) and (g) of the Health and Social Care Act (Regulated Activities) Regulations 2014 (Part 3).**

At our last inspection in February 2015 we found the home was dirty. Furniture and furnishings were soiled, there was cigarette ash on the floors, and people did not get the help

Inadequate

# Is the service safe?

they needed to keep their rooms clean. Audits (checks), to demonstrate that the home was being regularly cleaned were not in place. We told the registered provider to improve this area of service delivery.

On this visit we found the service employed a domestic, who worked for three hours each day, six days a week on a morning. Staff told us that these hours were insufficient to keep the home clean. We carried out a tour of the home which included people's bedrooms (where they allowed us to look at their rooms). We found that there were still more than 10 bedrooms which required decoration and new furniture and/or carpets. Two of the rooms viewed were smelly and unpleasant. One room still had a large stain on the ceiling. Some rooms had cigarette ash on the floor or were sticky to walk on. The carpet in the lounge was dirty and stained and although decoration was on-going the home was still not a clean and pleasant place for people to live and work. Audits were still very basic and did not sufficiently evidence deep cleaning tasks. Some people needed additional support to clean their rooms. We were told that each room was cleaned each week; however for some people this was not sufficient.

**Our findings demonstrated a significant and continued breach of Regulation 12(2)(h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3).**

Inadequate

# Is the service effective?

## Our findings

At our last inspection in February 2015 we found that staff were not being provided with appropriate support which enabled them to care for people safely and effectively. Whilst we saw that staff had completed a range of training, this had not always provided them with the right skills and knowledge to enable them to provide appropriate care that balanced the need for ensuring people's safety with the rights of people to take risks. Supervision of staff was managed informally. This meant there was no record to enable managers to follow up previous discussions, or check on the workers' understanding and knowledge. We told the registered provider to improve this area of service delivery.

During this visit we found that although staff received better support, their induction, training and supervision was still not providing them with the right skills to care for people safely. For example we spoke with some recently employed staff members, they confirmed that their induction had been very basic and had not enabled them sufficient time to read people's care plans. This meant that they may not know how to care for someone in the way they wanted or needed to be cared for.

We looked at staff training records. We saw that a number of courses had taken place since our last visit. This included mental health awareness, seven staff, health and safety and food safety, thirteen staff, first aid, five staff, safeguarding vulnerable adults, eight staff and moving and handling four staff.

We spoke with staff who said the following; "I have had training in managing behaviour, safeguarding adults and manual handling." Another staff member said "I have attended a range of training including infection control, safeguarding adults, manual handling, food hygiene, mental health awareness and medication awareness." However, despite this training we saw that medication was still not being administered safely, infection control practices were poor and staff were still not safeguarding people who lived at the home.

We saw from staff files that although supervisions had commenced they were still not taking place on a frequent basis. One staff member said "I have had two supervisions in two years." We looked at supervision records. One recorded a supervision in September 2013 and the next one recorded was January 2015. Another recorded a supervision in August 2013 and another in June 2015.

**Our findings demonstrated a continued breach of Regulation 18(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3).**

During our last inspection, we identified concerns regarding staff understanding and interpretation of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). Whilst we saw that nine out of sixteen staff had completed this training, other records we looked at did not reflect this improved knowledge.

During this visit we found that people's records now included information to demonstrate that their mental capacity was being assessed and considered when decisions about their care and support were being made.

We spoke with a member of staff who when asked, knew who was on a Community Treatment Order (CTO). They were able to tell us the conditions of the CTO and we saw that this was clearly documented in the person's care file, with clear instructions for staff on how to proceed were the conditions not adhered to. A CTO allows suitable people to be safely treated in the community rather than under detention in hospital. Carers needed to be aware of that order and the agreed conditions of that order. This is so that they could report non-compliance, which may be a reason for a recall to hospital.

The staff member was able to tell us which people had capacity and how this was assessed. Each care file we looked at had a capacity statement in place. It recorded when discussions around capacity had taken place and who was involved in those discussions.

The staff member was able to identify two people who had been deprived of their liberty. They had documented the way this had been assessed and were able to explain the process in terms of making a formal application for a DoLS authorisation. The evidence was clearly marked and in the care file. The member of staff told us that all staff had either participated in, or were booked on safeguarding and mental capacity training, so that staff could gain the knowledge and skills required.

However, we did see examples where people's views were not being sought. For example, the fire safety checklist

# Is the service effective?

stated 'Is there documented resident permission' there was a yes/no response yet none of these had been completed. We also saw that not everyone had the opportunity to be involved in their care records.

**Our findings demonstrated a continued breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3).**

We saw people had a care plan relating to their nutritional needs. We found that whilst people were being weighed, people who had been assessed as underweight were not always receiving their prescribed supplements. For example, we saw one person had been prescribed fortisip supplements to be taken twice a day after meals. We looked at the MAR chart to see if this had been given as prescribed and we saw a number of gaps. We saw only four entries between the 1 and 17 June 2015 where the supplement was recorded as given. We looked at food and fluid charts and saw that these were poorly completed. This meant that people identified at risk of malnutrition may not be receiving sufficient amounts of food or fluid. We also found weight recording charts which were not being completed as per the guidance in the care plan. This meant that staff may be unable to pass relevant information regarding people's nutritional needs to other health professionals.

Comments from people included "I like the food here, I always get two choices." However, some people said that they were not involved in any menu planning, meal preparation or cooking. This meant that their daily living skills were not being promoted. Others told us that they could help with tea. Staff confirmed that people were not allowed into the kitchen area.

We were given copies of the menus in place and were told that new menus were being developed from an outside catering company who would also deliver the meals to the home. This was being trialled during our visit.

**Our findings demonstrated a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3).**

We also identified concerns about the way people's general healthcare was being managed. We identified one person with diabetes, which is a diagnosed medical condition which if not well managed may need emergency care. Whilst we saw that information about their diabetes was recorded in the individual's daily records there was no plan of care relating to any emergency management. As we were concerned about this individual's health care we asked staff about this. However, they were vague in terms of response and we received conflicting information which meant that they may not recognise and report the person's healthcare needs as requiring urgent treatment.

We looked at people's health care records and saw some instances where information about their health needs was recorded. However, we found other instances where appropriate referrals to health professionals had not been made. An example included an individual with diabetes.

**Our findings demonstrated a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3).**

We asked people if they were involved in decisions regarding the environment. People told us that they had helped to choose colours for their rooms to be decorated. They spoke positively of the changes taking place. The home had spacious gardens which were well maintained in the area near to the home.

Inadequate

# Is the service caring?

## Our findings

We observed staff on duty who demonstrated a kind and caring attitude in their interactions with people living at the home. One person said, "The staff work hard, I like them, we get on alright and they don't shout at you." Other people told us that they liked the staff who cared for them.

We listened to and observed one member of staff in the smoking area. They were talking with three people. They listened to what people were saying and were kind and respectful throughout. They appeared to have a good rapport with people.

We observed one staff member offering to paint an individual's finger nails. When the individual expressed a preference for their toe nails to be done this was agreed, the staff member identified that their feet would first need to be cleaned and offered to take them to their room to do so.

During our last visit to the home we identified some concerns regarding how people were consulted as we found evidence which suggested that the service was being run to meet the needs of the staff, rather than the people who lived there. During this visit we found some examples where more efforts had been made to consult people; for example during residents meetings and we saw that some people had signed their agreement to their care records. However, there was still very limited evidence to show that people were being consulted on a daily basis and there was little information within people's care records to demonstrate that people's views and opinions were being sought.

During our last inspection, we noted 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. We noted one lady had dry, coated lips. During this visit we still found that some people looked unkempt. Their clothes and hair were dirty and dishevelled. Where people were refusing help and support with their personal care needs, the registered provider had failed to record what they were doing to address the issues and how they were providing support to people.

We saw from people's records that staff regularly offered choices to people and offered to help people with their personal care. However, we also noted that when people had declined this care there was little recorded to evidence what staff had done. Whilst we recognised that people had the right to decline care, we did not see reference in the care records we looked at, to evidence that staff had discussed with the individual the importance of maintaining good personal hygiene. We found that some people were regularly refusing any personal care and nothing was being done to gain advice and support regarding this. One person had not had a bath or a shower recorded for 3 months. Others had very few baths or showers recorded. For example; one person was said to have had a bath on the 9 June 2015 then previously on the 25 May 2015 there was nothing else recorded.

Despite the care staff's willingness to help people, and some positive comments from people living at the home, 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, not ensuring people were given their medicines as prescribed and not ensuring monitoring records were in place and well maintained.

**Our findings demonstrated a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3).**

We did not see sufficient evidence of staff working in partnership with people to improve their life skills and independence. We were told that some people cleaned their own rooms; however it was clear that some people were not managing this task appropriately and required support from staff. We saw one person's room which was dirty with cigarette ends on the floor and we were told that they were not able to clean it effectively. We did not see any evidence that people's abilities were being taken into account when care was being planned.

We saw from a residents meeting minutes that eight out of ten people said staff knocked on doors before entering their room. We did observe this during our visit.

We observed one member of staff communicating with an individual by writing things down. They were respectful when doing so and said this was the individual's preference.

**Our findings demonstrated a continued breach of Regulation 10 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3).**

Inadequate

# Is the service responsive?

## Our findings

At our last inspection in February 2015 we found people did not receive person centred care. This meant individualised care, in line with the person's assessed needs. We found when people's needs changed; their records were not always updated to reflect those needs. This increased the risk of people receiving unsafe or inappropriate care. We told the registered provider to improve this aspect of service delivery.

Care plans are an integral part of beginning to understand an individual and their needs, wishes and the way in which care should be provided. At this visit we found that the majority of people's care records had been re-written, to try to better reflect the care they needed. However, we still found that in some cases these records were basic and did not demonstrate they had been written in consultation with the individual. We identified inconsistencies with care plans. Some had signature sheets for staff to sign when read, others did not. One member of staff was aware that the care plans existed but had not read any.

There was evidence in some of the care plans that people had signed their agreement to their records. However, this was not the case for everyone. People had individual care plans which covered a range of areas for example, health, finances, personal hygiene, psychological well-being, diet and nutrition, communication, use of kitchen, occupation and activities and going out. However, care plans were of varying quality. One of the care plans identified useful ways in which to identify and respond to deteriorating mental health, for example weight loss may be an indicator of deterioration for one individual. The care plan offered ways to improve dietary intake, whilst considering how the person may be feeling, for example may prefer a quiet dining area, or to be offered snacks in between meals.

One person's care plan stated that they needed to be prompted to change their clothes or have a bath as they may forget to look after themselves. The daily records for this person recorded that baths were not taking place. There was no written evidence to demonstrate what the staff were doing about this.

We identified two people with diabetes whose care records stated that their blood sugar levels should be checked at regular intervals. Despite care records stipulating that checks could be carried out we found that these were not always being followed. There was no plan of care in their records to describe what staff should do should the individual's blood sugars fluctuate. This meant that in that situation the person may not get the right care and support because different care staff may respond in different ways. Care plans were needed so that care staff had clear guidance to follow in those circumstances. People's records needed to be regularly reviewed, up to date and provide an accurate account of the care and support people needed.

We looked at one person's blood sugar monitoring chart. It said 'BM to be done at least twice a day'. We saw that there were significant gaps in the recording on this chart which meant that staff may not be alerted to the individual requiring medical attention. This meant that staff were not following the care plans in place.

Care plans had not been reviewed and we were told by staff this was because they had been re-written, however we were shown a review list which detailed dates for each plan to be reviewed.

Some care plans had advance directives in place. These are legal documents that allow people to record decisions about end of life care ahead of time. They enable people to express their wishes to family, friends and health professionals to avoid confusion.

We saw some evidence in the seven care records we looked at to show that people had been asked to be involved in their care plans, but had been either unwilling or unable to sign their agreement.

**Our findings demonstrated a continued breach of Regulation 17(2)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3).**

People provided mixed views about the activities provided. One person told us they used to attend community activities before living at Haisthorpe House; they told us they now took part in activities at home. Another person said they were 'excited' as they were waiting for support staff to take them to mass and said this was the first time they had been able to attend for three months. They also stated that staff had until our visit been too busy to fix their wheelchair.

Inadequate

# Is the service responsive?

One person told us they were going on holiday and we saw this on the second day of our visit. They were clearly looking forward to going away. Another person we spoke with said that their family could visit whenever they liked. However others said there was not much going on.

Other people told us that they visited their friends, watched the football, attended a tea party at the home and went on outings. We saw people being asked if they wanted their nails doing, others were involved with activities with staff.

Some people were living more independently in flats which were also located on site. The flats were part of the registered home but enabled people to live more independently so that they could develop their skills with a longer term aim of moving out into the community. However we also found that some people in flats were less able to manage and required additional support particularly with domestic and self-help skills.

Two people we spoke with confirmed that they felt able to talk to staff about what was important to them and could express their views and opinions. One person said they would tell the new manager. They said “I have never had to complain, but if I did need to I would see the manager or a senior carer.” During our February 2014 inspection, we found that the home did not have an effective complaints procedure. During this visit we found that a summary complaints procedure was displayed on each person’s door in their bedroom. People told us that they would talk to the manager if they had any concerns. We saw one complaint had been made and we saw that this had been investigated and responded to.

Inadequate

# Is the service well-led?

## Our findings

At our last inspection in February 2014 we found the service was not well led. Checks on how the service was operating were not being routinely completed, the risk of harm to people was not being assessed, managed or kept under review, and the staff were not well supported. We told the registered provider to improve this aspect of service delivery.

At this inspection we found there was no registered manager employed, although the registered provider had employed a new manager who told us they were intending to apply to be registered as manager at the service. They had only been in post for five weeks when we visited so had therefore not had sufficient time or resources to address our on-going concerns at this home.

Prior to the manager being employed, the registered provider had employed the services of an independent consultant who had been attending the home five days each week. They had produced an action plan for the Care Quality Commission.

We were told that the registered provider had been visiting the service each week and carrying out their own checks. However, although some improvements were noted during this visit we identified a number of continued failings which meant that the registered provider had failed to identify the concerns, challenges and risks we found. This indicated their checking process was not sufficiently robust.

Staff told us that the service had improved and were positive about the new management arrangements; However, despite the positive comments from the care staff, we found there were still serious concerns about the way the service was being run. We found a number of audits were now being completed, which suggested that the service had improved. However the findings from these did not match our findings. For example a medication audit had been completed in May 2015. The audit had identified some concerns, but mostly indicated that medication processes were working well. At this inspection the pharmacist inspector found a range of concerns about the way medicines were being managed and some of these failures had impacted on people's health and well-being.

We saw an environmental audit had been completed in June 2015 that mostly indicated an improving service. We noted some re-decoration had been completed since our last inspection and that further rooms were due for refurbishment. However water temperatures were last recorded as checked on the 28 May 2015, window restrictor checks were completed on the 23 May 2015 and recorded that nine were without restrictors (six of which were painted shut) yet there was no evidence of any further action taken. We also saw a legionella survey dated March 2015 where a range of high priority, to address immediately, action points recorded. There was no evidence of this being addressed.

We also saw a gas safety certificate dated 3 April 2015 which made reference to the access to the loft boiler being required as soon as possible. This had not been done. In addition we saw a letter from City of York Council Health and Safety dated March 2015 and the actions from this letter had not been addressed.

In our February visit we identified a number of concerns in relation to fire safety and the maintenance and cleanliness of the building. During this visit we again identified significant concerns in this area. Fire checks which were recorded as being required hourly were not being completed. Some rooms had no checks recorded for fire checks whilst others had been checked four times daily yet only two checks were recorded.

Although the service now employed a domestic there was no indication that different areas of the service were being cleaned at different intervals, according to need. We noted three bedrooms in particular were dirty and smelly but there was no extra provision to manage this.

We found the service had a fire risk assessment, but fire safety checks were not always being completed in line with the home's fire policy. This increased the risk of harm to people. We noted other areas where the building was poorly maintained, reported elsewhere in this report. Following our visit we discussed our findings with the fire safety officer.

We noted the manager's office was sited in a separate building on the premises. This created an accessibility barrier for both people living at Haisthorpe House and the staff. This meant there was little opportunity for informal monitoring and observation of the quality of the care and support being provided. The manager was in the process of moving this across to the main house.

We also noted that although information about accidents and incidents at the service was now being gathered and

Inadequate

# Is the service well-led?

recorded, these were not accurate as staff had failed to recognise, record and report some people's behaviours and responses as safeguarding incidents, that needed reporting to both CQC and the local authority.

Staff told us that staff meetings were taking place and we were shown copies of the minutes of these. We were also shown copies of the minutes from resident's meetings. We noted that changes to how the service was operating were discussed in the staff meeting and there was recognition that improvements were still required. However despite meetings taking place we found that records in the service were poor and lacked significant information which was required to minimise risks and to reduce the risks of harm.

**Our findings demonstrated a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3).**

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 9 HSCA (RA) Regulations 2014 Person-centred care<br><br>People who use services were not protected against the risk of receiving care or treatment that was inappropriate or unsafe.<br><br>We have judged that this had a major impact on people who use the service. This is being followed up and we will report on any action when it is complete. |

**The enforcement action we took:**
We have cancelled the providers registration.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect<br><br>People who use the service did not always have their dignity and independence assured because the provider had not made suitable arrangements to treat people with consideration and respect.<br><br>We have judged that this had a moderate impact on people who use the service. This is being followed up and we will report on any action when it is complete. |

**The enforcement action we took:**
We have cancelled the providers registration.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 11 HSCA (RA) Regulations 2014 Need for consent<br><br>The consent of people who used the service was not always sought.<br><br>We have judged that this had a minor impact on people who use the service. This is being followed up and we will report on any action when it is complete. |

This section is primarily information for the provider

# Enforcement actions

**The enforcement action we took:**
We have cancelled the providers registration.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment<br><br>People who used the service were not protected against the risk of exposure to health care associated infections because the provider did not operate a system to assess the risk and prevent, detect and control the spread of infection. The provider did not maintain appropriate standards of cleanliness and hygiene in relation to the premises.<br><br>Medicines were not obtained, administered or audited appropriately which meant that people did not always receive their medication safely and as prescribed by their GP.<br><br>We have judged that this had a major impact on people who use the service. This is being followed up and we will report on any action when it is complete. |

**The enforcement action we took:**
We have cancelled the providers registration.

| 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<br><br>People who used the service were not safeguarded against the risks of abuse because the provider had not taken reasonable steps to identify the possibility of abuse before it occurred and had not responded appropriately to allegations of abuse.<br><br>We have judged that this had a major impact on people who use the service. This is being followed up and we will report on any action when it is complete. |

**The enforcement action we took:**
We have cancelled the providers registration.

| 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 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs<br><br>People who use the service were not always protected from the risk of inadequate nutrition and dehydration by means of the provision of support for the purposes of enabling them to eat and drink sufficient amounts to meet their need.<br><br>We have judged that this had a moderate impact on people who use the service. This is being followed up and we will report on any action when it is complete. |

**The enforcement action we took:**
We have cancelled the providers registration.

| Regulated activity | Regulation |
| --- | --- |
| Accommodation for persons who require nursing or personal care | Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment<br><br>People who use the services and others were not protected against the risks associated with unsafe or unsuitable premises because of inadequate maintenance.<br><br>We have judged that this had a major impact on people who use the service. This is being followed up and we will report on any action when it is complete. |

**The enforcement action we took:**
We have cancelled the providers registration.

| Regulated activity | Regulation |
| --- | --- |
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA (RA) Regulations 2014 Good governance<br><br>People who used the service were not protected against the risks of inappropriate or unsafe care and treatment, by means of the effective operation of systems and records, designed to enable the registered provider to regularly assess and monitor the quality of the service provided. |

This section is primarily information for the provider

# Enforcement actions

We have judged that this had a major impact on people who use the service. This is being followed up and we will report on any action when it is complete.

**The enforcement action we took:**
We have cancelled the providers registration.

| Regulated activity | Regulation |
| --- | --- |
| Accommodation for persons who require nursing or personal care | Regulation 18 HSCA (RA) Regulations 2014 Staffing<br><br>People who used the service were cared for by staff that were not appropriately supported by the provider to enable them to deliver care and treatment safely to people because staff had not received appropriate training, professional development and supervision.<br><br>We have judged that this had a minor impact on people who use the service. This is being followed up and we will report on any action when it is complete. |

**The enforcement action we took:**
We have cancelled the providers registration.