Mrs C A Jansz

Haslington Residential Home

Inspection report

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Tel: 01322383229

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

The inspection was carried out on 19 June 2018, and was unannounced.

Haslington is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Haslington is a two storey large Victorian house. Haslington can accommodate up to 46 people who require nursing or personal care and who are living with dementia. People's bedrooms are provided over three floors, with a passenger lift in-between. The three floors are for people with different dependency levels. The top floor is considered medium dependency, the middle floor is considered high dependency and the ground floor is considered low dependency. There are 31 people at the home at the time of the inspection. Both men and women live in the home. Some people are not able to verbally communicate their feedback and experiences of living in the home.

At our previous inspection on 24 and 25 January 2017, we found three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These breaches were in relation to ensuring that effective systems were in place to monitor the quality of the service and meeting people's needs and preferences to provide consistent care. Quality audit systems were not completely robust in identifying all shortfalls within the service and ensuring that any shortfalls identified were fully rectified. Activities were being provided but people and relatives told us that this was an area that still required improvement. Available activities were not being consistently communicated to people.

We asked the registered provider to take action to meet the regulations. We received an action plan on 3 April 2017, which stated that the registered provider would take action to become compliant with the regulations by the 10 July 2017. Improvements had been made in relation to meeting Regulation 12. However, further improvements were still required in relation to Regulation 17.

At this inspection, we found the service 'Inadequate' and the service is therefore in 'special measures.'

At the time of this inspection, the service was being managed by the registered provider. The registered manager had been off sick since 12 January 2018. The registered provider failed to notify CQC of the absence of the registered manager within the required timescale of 28 days. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the home. 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 home is run.

People's needs had been assessed. However, care plans did not have appropriate risk assessments that were specific to people's needs that would give staff appropriate guidance. Specific guidance documents about how to manage epileptic seizures, challenging behaviour and skin integrity were not provided for

staff. Care plans were not detailed and did not meet people's needs in a person centred way. The registered provider had not responded to changes in people's needs quickly or appropriately.

People are not supported to have maximum choice and control of their lives and staff do not support them in the least restrictive way possible; the policies and systems in the service do not support this practice.

There were no effective quality audit systems in place to enable the registered provider to assess, monitor and improve the quality and safety of the service.

There were limited activities located around the service for people to be engaged with. Not everyone was engaged in activities during our inspection. People told us they were bored and relatives were not satisfied with activities in the service. We made a recommendation about this.

There appeared to be enough staff to support people, but they were not appropriately deployed. We observed that staff were visibly present and providing support and assistance on the middle floor. On the top floor, however, we observed that there were periods when people were completely unattended to by staff. We have made a recommendation about this.

Staff showed they were caring. However, we observed that people's privacy and dignity was not always respected.

People were safe from the risk of abuse at Haslington Residential Home. Staff knew what their responsibilities were in relation to keeping people safe from the risk of abuse. Staff recognised the signs of abuse and what to look out for. There were systems in place to support staff and people to stay safe. Medicines were managed safely and people received them as prescribed.

People were supported by staff that had been recruited safely and had checks undertaken to ensure they were suitable for their role. Staff received regular training and supervision to help them meet people's needs.

The registered provider ensured the complaints procedure was made available if people wished to make a complaint. People, relatives and staff told us that the registered provider was approachable.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.
The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Risks to people's safety and welfare had not been adequately managed to make sure they were protected from harm.

There appeared to be enough staff on duty. However, there was a need to review staffing deployment to ensure there were suitable staffing numbers on each floor to support people's needs.

Staff knew how to recognise any potential abuse and to help keep people safe.

The registered provider followed safe recruitment practices.

Medicines were managed and recorded in a safe way.

Is the service effective?

Inadequate

The service was not consistently effective.

People's needs were fully assessed with them before they moved to the home to make sure that the staff could meet their needs. However, the registered provider had not responded to changes in people's needs quickly or appropriately.

Staff showed limited knowledge of Deprivation of Liberty Safeguards and Mental Capacity Act (2005).

Staff received on-going training in areas identified by the registered provider as key areas. Supervisions and appraisals were carried out by the registered provider.

People were supported to be able to eat and drink sufficient amounts to meet their needs.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Staff did not protect people's privacy and dignity.

Staff were aware of people's preferences, likes and dislikes.

Wherever possible, people were involved in making decisions about their care.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

There were activities located around the home for people to engage in. However, this needed to be improved upon as people and relatives were not satisfied with the level of activities available.

Care plans were in place; however, they had not reflected people's current needs.

Staff continued to help people to stay in touch with their family and friends.

The registered provider had a complaints procedure and people told us they felt able to complain if they needed to.

Is the service well-led?

Inadequate

The service was not consistently well-led.

The systems and processes to monitor and improve the service had not been effective in highlighting the issues we found at this inspection.

The registered manager was off sick when we inspected. However, the registered provider was managing the service.

The registered provider did not send CQC a statutory notification regarding the absence of the registered manager within the required 28 days and had not submitted notifications regarding DoLS authorisations.

The registered provider sought people and staff's feedback and welcomed their suggestions for improvement.

Haslington Residential Home

Detailed findings

Background to this inspection

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

This was a comprehensive inspection, which took place on 19 June 2018 and was unannounced.

The inspection was carried out by two inspectors and an expert by experience. An expert by experience is a person who has personal experience of using similar services or caring for older family members.

Before the inspection, we asked the provider to complete 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. We looked at previous inspection reports and notifications about important events that had taken place in the service, which the provider is required to tell us by law. We used all this information including the Provider Information Return to plan our inspection.

Some people were unable to tell us about their experiences, so we observed care and support in communal areas. We spoke with ten people who used the service. We also spoke with five visiting relatives.

We spoke with five care staff, two senior care staff, one cook and the registered provider.

We looked at the provider's records. These included five people's care records, which included care plans, health records, risk assessments and daily care records. We looked at six staff files, a sample of audits, satisfaction surveys, and policies and procedures.

We asked the registered provider to send additional information after the inspection visit, including staff

recruitment related records and care related information.

The information we requested was sent to us in a timely manner.

Requires Improvement

Is the service safe?

Our findings

At our last inspection on 24 and 25 January 2017, we identified a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered provider had not done all that was reasonably practicable to mitigate risks. People's medicines were not being correctly managed.

At this inspection, we found that improvements had been made. We found that processes were in place to ensure people's medicines were ordered, stored, administered, recorded and disposed of safely. We observed the senior care staff administered people's medicines safely. We noted staff helped people with their medicines in their own individual preferred way, with extra support as required. Staff then signed people's medicine administration records (MARs) which were checked for completeness at the end of each staff shift. This breach was now met.

Some people required topical creams for their skin, which care staff administered. We noted the topical creams were recorded on MARs and there were no gaps in staff signatures. When PRN (as required) medicines were administered, the reason for administering them was recorded within the MAR chart. This indicated that the registered provider had an effective system in place for the administration of medicines safely.

Suitably trained staff followed the arrangements in place to ensure people received their prescribed medicines. We found the management of controlled drugs, which are medicines requiring additional measures to ensure they are managed securely, was safe. Records showed two staff always signed when a person was administered a controlled medicine, including if these were administered during the night shift and these records were audited daily. Staff told us and records confirmed that only the senior care staff administered medicines and they had undertaken the provider's medicines training and had their medicines competency assessed annually to ensure their practice was safe.

At this inspection visit, we found that risk assessments were not always linked to care plans. They did not give full details about the risks to people in certain areas such as skin integrity, and did not detail any mitigation to reduce the risk. For example, in one person's care plan it stated, 'Risk due to 'X' being doubly incontinent and sitting for long periods. How to manage the risk – Good personal care, spenco cushion when 'X' is sitting'. There were no further control measures in place and there was no skin monitoring chart. In another person's care plan, we found that they had been having more frequent epileptic seizures. Staff had called the doctor accordingly. On 21 March 2018, the doctor had seen this person due to them having three seizures that morning. Staff had been requested to monitor and keep the doctor up to date with progress. We found there was no monitoring chart in place and no specific care plan or risk assessment regarding the management of seizures.

Furthermore, there were no nutritional or challenging behaviour risk assessments for people in the service who had specific nutritional needs or required behavioural support. There was no guidance for staff about how to manage epileptic seizures, challenging behaviour and skin integrity. One healthcare professional told us, 'I observed three people eating very little, if anything at all. No support offered. No monitoring of

food and fluid intake seen for these people and one resident was being inappropriately fed whilst in slumped position in chair'. Comprehensive risk assessments would have mitigated identified risks for people being supported.

The registered provider had not taken appropriate action when accidents and incidents had occurred to mitigate the risk of the same issue happening again. Where accidents or incidents occurred, staff responded appropriately. Staff took actions to ensure that people were safe following incidents such as falls or illness. The registered provider kept a record of any accidents or incidents that occurred and documented the actions taken in response to them. While the registered provider analysed accidents and incidents each month, there were no comprehensive action plan put in place to mitigate a repeat. For example, one person had a fall three times on a night shift. The time of the falls were established as between 9 and 10pm however the action set was inadequate. Action stated, 'Can night staff check and review care plan, monitor for any triggers.' We found no records of any monitoring or any further action/s taken. This showed that the registered provider did not have a comprehensive system in place which would have enabled them to learn lessons from, and respond to, repeated risks.

The registered provider had not fully mitigated the risks to people's health and safety. The examples above were breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Risk assessments were in place regarding tasks that staff were required to undertake that could prove hazardous to health. For example, there was a lone working risk assessment for staff working in the laundry and there was a risk assessment in place for leaving the tumble drier running in the absence of staff. The registered provider carried out internal checks of mattresses, pressure cushions checks and checks of electrical profiling beds. These were serviced yearly, which ensured people's safety.

The risk of abuse were minimised because staff were aware of safeguarding policies and procedures. All staff were aware of the company's policies and procedures and felt that they would be supported to follow them. Staff also had access to the updated Kent and Medway local authority safeguarding policy, protocol and procedure. This policy is in place for all care providers within the Kent and Medway area. It provides guidance to staff and to managers about their responsibilities for reporting abuse. Staff told us that they would refer to this guidance whenever required. All staff said they would report any suspicion of abuse immediately. A member of staff said, "Safeguarding is about the protection of people from all harm such as abuse. If I suspect anything, I will report to my line manager." Staff told us that they felt confident in whistleblowing (telling someone) if they had any worries. The registered provider also had information about whistleblowing on a notice board for people who lived in the service and staff.

There appeared to be enough staff to support people and meet their needs. Staff rotas showed the registered provider took account of the level of care and support people required, both in the service and when out in the community, to plan the numbers of staff needed each day to support them safely. There were two senior care workers and six care workers on every shift. In addition, there was one part time activities coordinator [three days a week] and ancillary staff, including one handyman, one laundry person, one cook, one kitchen assistant and two domestic staff. Records confirmed this level of staffing. However, we observed that whilst staff were visibly present and providing support and assistance on the middle floor, there were periods when people on the top floor were completely unattended to by staff as the top floor was considered medium dependency by the registered provider. We observed that four out of eight people in the top floor lounge were dozing or asleep while one lady was slumped in her chair with her head on the arm rest between 10.35am and lunchtime. Throughout this period, we saw only one member of staff on the top floor. There was little interaction between the staff and people in the lounge apart from the television that

was on and one person who had a visitor with them.

We recommend that the registered provider reviews the deployment of staff on the top floor to adequately meet the needs of people.

We checked recruitment records to ensure the registered provider was following safe practice. The registered provider had carried out sufficient checks to explore staff members employment history to ensure they were suitable to work with people who needed support. We reviewed four staff files and saw that recruitment processes were always fully carried out in line with Schedule 3 of the Health and Social Care Act 2008. Gaps in employment histories were fully explored. Two references had been received before staff started work. Records showed that staff were vetted through the Disclosure and Barring Service (DBS) before they started work and records of checks were kept in staff files. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with vulnerable people who use care and support services.

At our last inspection, we recommended that the registered manager put in place systems to effectively record learning experiences from fire drills. At this inspection, we found that there was an up to date fire risk assessment for the building and information about fire safety had been shared with people living at the service and visitors as well as staff. There were regular checks on fire safety equipment, gas and electrical safety, water supplies and window restricting devices. These had been recorded and action had been taken when concerns were identified. The provider's contingency plan was available in the service's foyer along with an emergency equipment box and fire safety information. The service was well lit, with plenty of room to move around. People had been assessed as requiring staff support to evacuate the building if a fire broke out or some other emergency situation arose. People continued to have a comprehensive individual personal emergency evacuation plan (PEEP) in place. A PEEP sets out the specific physical, communication and equipment requirements for each person and must ensure they could be safely evacuated from the service in the event of an emergency. The environment and equipment used by people was safely maintained.

There were systems in place to prevent and control the spread of infection. The domestic staff were aware of their protocols for work, responsibilities and schedules of cleaning. The equipment they used for cleaning was colour coded. We observed that the environment was clean and odour free during our inspection. There were sufficient domestic staff and they were busy throughout the day. The registered provider carried out infection control audits where any concerns were identified. These had been acted on. All staff wore personal protective equipment, such as gloves and aprons. These were disposed of after use. There was a schedule for checking and cleaning equipment, such as mattresses, hoists, slings and commodes; and the registered provider checked that staff were following these.

A business continuity plan was in place. A business continuity plan is an essential part of any organisation's response planning. It sets out how the business will operate following an incident and how it expects to return to 'business as usual' in the quickest possible time afterwards with the least amount of disruption to people living in the home.

Inadequate

Is the service effective?

Our findings

At our last inspection on 24 and 25 January 2017, we recommended that the registered provider puts in place systems to ensure that the principles of Mental Capacity Act 2005 (MCA) were embedded within the service delivery.

At this inspection, we found that there were mental capacity assessments in people's care plans however they were not completed in line with the legislation.

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 authorisation 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.

The service was not working in accordance with the MCA and associated principles. Where people could consent to decisions regarding their care and support this had been documented. However, where people lacked capacity, the appropriate best interest processes had not been followed. For example, a mental capacity assessment in one person's file dated 17 September 2017 said it was for "Restriction of 'X' rights as 'X' infringes on others rights by taking their clothes and belongings and 'X' does not understand the consequences of their actions as fellow people will become abusive towards 'X'". There was no clear detail about how the person's rights were being restricted. The record then went on to say, 'All decisions made around their best interests are agreed by manager and care staff'. It had not been signed by a responsible healthcare professional or someone with lasting power of attorney [LPA]. There was no documentary evidence that a best interest meeting had taken place. In another example, we saw an MCA assessment which stated the person would have 'two hours bed rest in the afternoon'. There was no information about whether this had been advised by a healthcare professional or a best interest meeting had taken place. It was recorded that it had been discussed with a relative who was listed as having power of attorney [POA]. Power of attorney gives one person the authority to act on behalf of another person for a short period of time. However, there was no documentation to support that the daughter had lasting power of attorney [LPA] for health and welfare. LPA had no expiry date and allow another one person to make decisions on their behalf of another. The relative was listed as next of kin and advocate on other MCA forms so it was unclear what their role was. The section for POA to sign had also been left blank. This showed that the registered provider failed to apply the principles of MCA 2005 within the home in a person centred manner which involved people in decisions about their care.

Failure to apply the principles of MCA 2005 was a breach of Regulations 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some applications to deprive people of their liberty had been made and authorised by the appropriate body. Records showed that 13 people were listed as having a DoLS authorisation in place with a further 16 applications in progress. The registered provider was unable to tell us the status of the 16 applications. The registered provider said, "Everyone was under DoLS". Authorised DoLS had not been appropriately notified to CQC. This is a breach of the regulation.

The registered provider undertook an initial holistic assessment with people before they moved into the home. The assessment checked the care and support needs of each person, which enabled the registered provider to make sure they had suitable numbers of skilled staff to care for the person appropriately. People's initial assessment led to the development of their care plan. People's care plans included personal information to make sure they were supported to express their sexuality. One person expressed their wish in their care plan requested that staff helped them to look clean and tidy as this was something that was always very important to the person through their life. They also liked their hair to be neat and well groomed. The care plan showed the person's styled their hair regularly by the hairdresser in the service. People's cultural needs were identified and the support each person required was recorded, for example, if they needed support to attend a place of worship or be able to worship in the service.

People were supported to maintain their health with health care professionals such as GP's, district nurses, and community nurse practitioners as records were kept of referrals, appointments and visits.

Staff told us they received the training and updates they required to carry out their role. However, staff had not received epilepsy training, which would have enabled them to understand how to adequately support people with epilepsy. New staff received a full induction into the service and their new job and underwent a period of shadowing more experienced staff until they were confident and competent. Staff told us they had a good induction and felt able to ask the management team questions if need be. The staff training records showed that all staff had attended refresher training identified by the provider such as moving and handling, safeguarding and fire awareness. Training certificates in staff files which confirmed this.

Staff continued to have regular one to one supervision meetings and an annual appraisal of their work performance with the registered provider. This provided opportunities for staff to discuss their performance, development and training needs and for the registered provider to monitor this. Supervision is a process, usually via a one to one meeting, by which an employer provides guidance and support to staff.

There was a general consensus from both visitors and people that the range and quality of food was "good". People were supported to have enough to eat and drink and were given choices. People were complimentary about the food that was prepared for them. One relative appreciated the menu flexibility and told us that the chef only needed to be alerted to resident's particular preference and would make adjustments to suit. They said, "Dad can't stand mash, so he always gets new potatoes instead". Care records contained information about people's food likes and dislikes and there was helpful information on the kitchen notice board about the importance of good nutrition, including the source and function of essential minerals for both staff and people to refer to.

There were morning and afternoon snacks which were varied. It was a very warm day when we inspected and we saw people were offered ice lollies. Fresh, seasonal easy to eat fruits were also available. Drinks were freely offered to people and if requested at any time of the day, in addition to the scheduled mid-morning and mid-afternoon serving. We observed staff ate with people, making mealtimes a more social and positive event. In doing so they were able to encourage people to eat.

The premises had been designed and decorated to meet the needs of the people who used the service. The

middle floor, which provided care for people in the advanced stages of their dementia, had been decorated with bright colours, textured wallpaper and wall activities for people to touch and feel. The hallways were decorated with items and paintings that may remind people of certain times in their lives. There was a quiet room for people to use if they wanted a place to go that was quiet and away from the main communal areas. There were clear signs throughout the service that identified what room a person was about to enter with clear wording, bright colours and a picture.

Requires Improvement

Is the service caring?

Our findings

We observed that some people were supported by caring staff. People on the ground floor and middle floor looked relaxed, comfortable and at ease in the company of staff.

Visiting relatives said, "We are very happy with everything here"; "I like the personal approach to residents" and "They try to honour my Dad's wishes and give him privacy".

Although a visiting relative told us that staff tried to give their dad privacy, we found on the day we visited that staff did not always respect people's privacy and dignity. For example, we asked to use the toilet and the registered provider said, "We usually use 'X' toilet as the person who resides in the room do not use their toilet". We were then shown through to the person's bedroom to use the toilet, which was inappropriate and did not respect the person's privacy. One person said, "I do not feel safe at night. Other people come in to my room. I do tell staff, but it carries on." We spoke with staff and followed this up with the registered provider but they all had no recollection of this. This meant that people were afraid of intrusion into their privacy at night.

We observed poor practice on the top floor. People were often left unattended. When staff attended to them, we saw poor practice. A staff member woke one person up to go to lunch. The person said, "I'm ever so tired" but the staff member got them up and gave them their walking frame to walk to the dining room. The person appeared disorientated and was not given an opportunity to wake up properly and consider whether they wanted to go to lunch straight away. The person then panicked and said they were 'nearly going to the toilet'. The staff member responded, "That's ok, we can stop for the toilet on the way".

Another person said they did not want to go to lunch and a third person did not want to go immediately. After several attempts to encourage them, the care staff moved to ask other people however no one was asked if they would prefer their lunch in the lounge. Another person was then woken up to go for lunch. Two care staff tried to get this person straight up to their frame however they were still sleepy and disorientated and unwilling to get up. The two staff persuaded them to get up by telling them they could have a cup of tea in the dining room. Another person also said they were feeling tired but the registered provider and two care staff tried to persuade them to go for lunch. The registered provider said loudly, "Are we going to use the hoisting belt for her or can she stand". The care staff replied that the person would be better with the belt. The person was reluctant to stand and eventually the decision was made to bring them a cup of tea in the lounge. Approximately 10 minutes later, a member of care staff returned with a cold drink for her. No one had asked the person what they would like to drink and the person was expecting a cup of tea.

Failure to treat people with dignity and respect was a breach of Regulations 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We did, however, observe numerous pleasant interactions between people and staff during our visit. In the morning, we observed staff sitting with one person in the lounge in the middle floor. Staff were holding hands with the person and singing as the person smiled and nodded along to the tune.

People were involved in their care both on the middle floor and ground floor. People were able to go to bed and get up when they chose and this was recorded in their care plans. We observed one person stayed in bed until late in the morning. We asked staff about this and we were told that that was their choice which they respected.

People's bedrooms and the corridors were filled with their own personal items, which included pictures, furniture and ornaments. The staff on the ground and middle floors engaged people in conversation about their past histories, which included past occupations and family trees. Staff therefore had a good understanding of people's personal history and what was important to them.

Staff respected confidentiality. All confidential information was kept secure in the office. Records were kept securely so that personal information about people was protected. Staff helped people to stay in touch with their family and friends. People's relatives told us that they were able to visit their family member at any reasonable time and they were always made to feel welcome.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection on 24 and 25 January 2017, we identified a continuing breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered provider had not ensured that activities were person centred and were being appropriately recorded and communicated to people living at the service.

At this inspection, we found that some improvements had been made to some areas of activities in the home, however further improvements were required.

The registered provider had employed an activities coordinator following the last inspection who planned and facilitated a number of group and individual social activities two days a week. The activities coordinator was also the hairdresser in the home. There were limited activities organised, when the activities co-ordinator was not there. There were occasional outside entertainers hired to come into the home such as Gospel singers. Record showed that people were engaged in limited in-house activities such as ironing, participating in a sing along, listening to music, occasional hand massage and watching a film. Records showed that 12 people visited the local popular fast food restaurant weekly and received complimentary hot beverages and cakes. We saw an activities timetable for Mondays to Fridays. But the activities for the day of inspection such as crazy golf for the people on the top floor did not happen as the activities co-ordinator was on annual leave. However, there was a need for further improvements as some people did not seem to be interested in the available activities. One person said, "I am so bored, there is nothing to do, that is why I'm sleeping. I just drift through each day". Visiting relatives said, "There do not seem to be many activities", "I wish they would do more with them", "There are no activities. That entertainment board, I do not believe a word of it. My dad's notes say, 'Joined in with singing'. I have never ever seen that in three years".

We recommend that the registered provider seek advice and guidance from a reputable source, about the provision of meaningful activities responsive to the needs of people living in the service.

Care plan templates covered all aspects of people's daily living and care and support needs. The areas covered included medicines management, personal care, nutritional needs, communication, social needs, mobility, psychological needs, cultural needs and skin integrity. However, individual care plans had not been fully completed, were not detailed and did not set out guidance to staff on how to support people in the way that their needs would be met. In some care plans, there were some references to challenging behaviour that people sometimes displayed however there were no monitoring charts in place and no oversight of the frequency or seriousness of the behaviour. Although there were some details about how some people could display challenging behaviour, there was minimal information for staff about how to respond or what could cause it. It was difficult to see from people's care plans, risk assessments and daily notes when they had been verbally or physically aggressive or what had been done to reduce the risk of it happening again or how the situation had been de-escalated. For example, in one person's personal care plan it stated, "Will become agitated even with good communication skills". The care plan had been updated on 22 May 2018 but did not give staff any guidance on how frequently this occurred or if any other methods had been tried to reduce the distress to this person.

Some of the people had diabetes. There were no specific care plans in place for people with diabetes. There was no specific guidance for staff to explain how diabetes affected each person individually and what signs they should look out for to see if the person was becoming hypoglycaemic or hyperglycaemic. We looked at two care files for people with diabetes. In one of them, there was reference to diabetes in their nutritional care plan; however, the information was not clear about what they should or shouldn't eat to ensure that their health remained stable. The other person's care plan made no reference to diabetes at all. For example, one nutritional care plan stated the person was a type 2 diabetic, and this was controlled through diet and with medication. Staff were advised to 'monitor 'X' sugar intake'. There was no monitoring in place, and no specific guidance for staff on how to monitor the person's sugar intake or if there were specific foods that they could or couldn't have. The second care file did not contain a diabetes care plan and there was no reference to diabetes in their nutritional care plan. We asked the registered provider to check but they were unable to find specific diabetes care plans in people's care files.

Some people's care records stated that they had epilepsy. However, there were no specific epilepsy care plans in people's care files. One person had been prescribed medicines due to an increased number of seizures however there was no information in their care plan which mentioned their seizures or gave staff specific guidance around how to monitor or escalate concerns if the person experienced a seizure.

There were no monitoring charts for seizures in care files that were reviewed. When staff were asked where they kept monitoring charts for epileptic seizures, they said they did not complete any unless they needed to and they couldn't think of anyone who needed one. There were no charts for anyone for food and fluid, challenging behaviours, seizures or diabetes so we were unable to analyse any information about people to get a picture of how their health needs were being met. We asked the registered provider if they carried out any monitoring for areas such as challenging behaviour. They said, "As speech and language therapist [SALT] no longer come out and they expect us to diagnose and treat ourselves now, we don't evidence it for anyone anymore".

We found that people had monthly weight checks but where concerns were identified, these were not always acted upon. In one person's record we found that they had been losing weight steadily but no comprehensive action was taken. On 7 May 2018, one person had lost 3.4kg. Action stated, 'Care plan in place'. When weighed on 18 June 2018, the same person had lost 1.1kg. Record of action taken was stated as 'review care plan'. During the same period, another person lost 7kg from 85kg to 78kg in one month. The record of action taken stated, 'Care Plan not in place'. We checked both care plans with a senior care staff and found no further entry in relation to healthcare professional's intervention, which could have supported care staff in meeting this person's needs. A healthcare professional commented 'One person had lost 6kg in one month. No evidence to explain weight loss or action taken. Remained on monthly weighting, no referral to GP or dietitian or monitoring of food and fluid intake. Malnutrition Universal Screening Tool [MUST] is not completed'. These showed that the quality audit system and record keeping were not effective and they were inadequate, the registered provider failed to address people's weight loss.

Failure to meet people's needs in a person centred way, which is specific to the individual was a continued breach of Regulations 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the time of our inspection there was no one receiving end of their life care. Some people had been asked about their wishes if they became unwell, such as to be kept at the home and not wishing to be resuscitated. All care plans we reviewed contained completed 'do not attempt cardio pulmonary resuscitation [DNACPR]' information. The DNACPR is to provide immediate guidance to those present, particularly healthcare professionals on the best action to take [or not take] should the person suffer cardiac arrest or die suddenly.

The registered provider had a comprehensive complaints policy that included information about how to make a complaint and what people could expect to happen if they raised a concern. The complaints procedure was on display on the notice board in the home. The policy included information about other organisations that could be approached if someone wished to raise a concern outside of the home such as the local government ombudsman. There had been one complaint received in the last twelve months and this was resolved satisfactorily. A compliments log showed that the home had received several thank you cards and letters from relatives in the last 12 months. One relative wrote, 'Knowing 'X' is happy!!!! Knowing 'X' has people like you around them makes me feel so blessed and secure and it just makes everything I am going through worthwhile ……. I am very grateful to all of you at Haslington House'.

Inadequate

Is the service well-led?

Our findings

At our last inspection on 24 and 25 January 2017, we identified a continuing breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered provider had not ensured that there was an appropriate auditing system in place.

At this inspection, we found that the registered provider had not developed comprehensive systems to continuously learn, improve and innovate the service. There were some audit systems in place, however they were not fully effective in assessing, monitoring and improving the quality and safety of the services provided and they had not identified the issues we found at this inspection. For example, there were no comprehensive risk assessments or detailed guidance in place to inform staff how to care for people with for diabetes, epilepsy or challenging behaviour. The registered provider has failed to meet Regulations 9, 10, 11 and 12 of The Health and Social Care Act (Regulated Activities) Regulations 2014. This evidences that they have not measured and reviewed the delivery of care and support against current good practice guidance.

Records were not adequately maintained. There were no systems in place to record food and fluid intake or seizures for people who needed monitoring in these areas. There was a mixture of paperwork because the registered provider told us that they were in the middle of selling the service to another provider. hence new paperwork which was being implemented as we observed during the inspection. This meant that there were no comprehensive record keeping in the service which had not enabled staff to meet people's needs.

There was a registered manager in post at the time we inspected however, they had been on sick off since 12 January 2018. The registered provider had been managing the service since January 2018. The registered provider was an experienced manager who had been working in the home for several years. Registered providers are required to tell CQC of the absence of a registered person for 28 or more consecutive days. CQC received notification of the registered manager's absence on 12 March 2018. This informed us that the registered manager had been off sick since 12 January 2018. The statutory notification was sent to CQC 58 days after the absence of the manager.

The failure to operate effective systems and processes to assess, monitor and improve the quality and safety of the service and failure to ensure records were accurate, complete and consistent was a continued breach of Regulation 17 of The Health and Social Care Act (Regulated Activities) Regulations 2014.

The registered provider did not have a good understanding of the requirements of their registration with the Care Quality Commission (CQC). Necessary notifications relating to DoLS had not been made to CQC.

Failure to notify CQC of DoLS authorisations was a breach of Regulation 18, Care Quality Commission (Registration) Regulations 2009.

Staff told us that the provider encouraged a culture of openness and transparency. Staff told us that the provider had an 'open door' policy which meant that staff could speak to them if they wished to do so, and they worked as part of the team. A member of staff said, "The provider is very supportive, caring, listens and

always supports". Another staff said, "The provider is approachable. I feel relaxed with 'X'". We observed this practice during our inspection. Relatives felt they were listened to and that things were sometimes changed as a result of speaking up.

Communication within the service continued to be facilitated through several meetings. These included residents' meetings, housekeepers meetings, kitchen staff meetings, senior staff meetings and the activity coordinator's meeting with the registered provider. The minutes of meetings in April and May 2018 showed that meetings provided a forum where areas such as staff training, rota, activities, CQC visit and business plan were discussed. Staff told us communication had improved between staff, people, and the management.

The registered provider had systems in place to receive people's feedback about the service. The registered provider had recently received feedback from a survey carried out with relatives. Of the 21 questionnaires sent out, 12 were returned. The response from these showed that people were happy with the service. Comments included, 'I feel very lucky to have found Haslington. I feel it provides an excellent level of care and structure in mum's life' and 'Mum is always clean and tidy and I couldn't wish for a nicer place for her'.

It is a legal requirement that a provider's latest CQC inspection report rating is displayed at the home where a rating has been given. This is so that people, visitors and those seeking information about the home can be informed of our judgments. We found the registered provider had conspicuously displayed their rating at the service. The service had no website.

The registered provider worked closely with other organisations such as the commissioning authorities. However, the healthcare professional that gave us feedback was not satisfied with the service provision and management of the home. They commented, 'Requested managers last main and satellite kitchens audit but not received'.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The registered provider failed to notify CQC of DoLS authorisation.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The registered provider failed to provide specific guidance to staff in order to meet people's needs in a person centred way. Regulation 9

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The registered provider failed to ensure that people were treated with dignity and respect. Regulation 10

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The registered provider failed to apply the principles of Mental Capacity Act 2005 when assessing peoples' capacity to consent to their care.

Regulation 11

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered provider had not fully mitigated the risks to people's health and safety. The registered provider had not taken appropriate action when accidents and incidents had occurred to mitigate the risk of the same issue happening again. This is a breach of Regulation 12 (1)(2)(a)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered provider failed to ensure adequate audit systems were in place to regularly assess and monitor the quality and safety of the service and ensure consistent record keeping. This is a continued breach of Regulation 17 (1)(2)(a)(b)(c)