Hazel House Nursing Home Limited

Hazel House Care Home

Inspection report

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Ratings

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

Overall summary

This inspection took place across two dates 14 & 15 July 2015 and was unannounced.

The last inspection of Hazel House Care Home was 28 October 2014 and the service was rated as good, with a requires improvement rating in place for 'is the service effective'. No regulatory breaches were found.

Hazel House is set in its own grounds and is located on the outskirts of Leyland town centre. The home has two floors with a passenger lift. The home provides personal care for up to 43 people. At the time of our inspection 27 people lived at Hazel House Care Home.

The manager was available throughout our visits and received feedback during, and at the end of the inspection. The manager was employed by the provider in June 2015, the manager told us that they intended to apply to 'The Commission' for registered manager status.

Summary of findings

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.

We engaged with all people living at the home, feedback varied due to some people having limited communication skills. We spent time observing care delivery and spoke with people who visited the service.

We received mixed feedback when we asked people if they felt safe living at Hazel House Care Home.

We found that people were not always protected against avoidable harm and quality assurance systems at the home failed to identify or resolve associated risk, therefore placing people at significant risk of harm and neglect.

We found that people's safety was being compromised in a number of areas. This included how people were assisted to eat and drink, unsafe moving procedures, how well medicines were administered,
infection prevention, staff knowledge of essential care standards and suitability of pre-employment checks for staff prior to recruitment.

We found a number of premises issues that compromised peoples safety, these included; garden security, lighting in bathrooms, unsecure hand rails and failure to undertake monthly maintenance checks. The home had a distinctive malodour throughout communal living areas.

The principles of the Mental Capacity Act 2005 (MCA) had not been embedded into practice and we identified concerns relating to how people's mental capacity had been assessed prior to depriving them of their liberty.

We found insufficient evidence of staff training and development. Staff told us that they felt supported by the new manager, however explained that they have not felt confident to disclose their concerns to previous managers at the service and they felt this had contributed to a deterioration in care standards.

We found that people's dignity was not always considered. People were not responded to in a timely manner and we observed people to have unmet needs, such as calling out in pain, asking for the bathroom and requesting support. Staff did not seem to acknowledge non-verbal signs of communication for people living with dementia and we observed care to be task focused.

We found that people's health care needs were not appropriately assessed therefore individual risk factors had not been fully considered, placing people at risk of avoidable harm. We looked at care records and found significant gaps in reviews of people's needs. Care planning was not person centred.

We received variable feedback from relatives; some expressed positive comments about the care provided whilst others were concerned about the lack of responsiveness from the provider when they raised concerns.

We did not find evidence of robust management systems in the home and quality assurance was not effective in order to protect people living at the service from risk.

Staff were not provided with effective support, induction, supervision, appraisal or training. The home did not have effective governance systems in place to ensure that improvements can be made.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to peoples safety, staffing, the safe administration of medicines, nutrition and hydration, premises safety, governance, person centred care and dignity and respect. We have deemed that the overall rating for this service is inadequate.

We found people living at the service experienced inadequate care which in some cases had a imminent risk to their health and wellbeing.

We want to ensure that services found to be providing inadequate care do not continue to do so. Therefore we have introduced special measures. The purpose of special measures is to:

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

• Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.

Summary of findings

• Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to cancel their registration.

Services rated as inadequate overall will be placed straight into special measures. You can see what action we have taken at the end of this 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.

There were not appropriate and effective systems in place to identify the possibility of risk and to prevent harm to people living at the service.

The processes in place to ensure that people received their medicines as prescribed were not robust and placed people at risk of harm.

The systems in place to protect people from infection were not robust.

There were not effective systems in place to maintain premises safety.

People were not safeguarded against risk of neglect and avoidable harm.

Recruitment systems were not robust to ensure the safety of people living at the service.

Staffing levels at the home did not support effective provision of care standards.

Is the service effective?

Inadequate

The service was not effective.

New staff had not completed a formal induction programme when they started to work at the service. Therefore, they were not adequately skilled to provide the care people needed or helped to familiarise themselves with the policies and procedures at the home.

Supervision and appraisals for staff were in some cases overdue and staff were not well supported in their work performance.

Training records were not reflective of competency based marking systems, therefore we could not establish if staff were adequately trained to provide safe and person centred care.

People's rights were not always protected, in accordance with the Mental Capacity Act 2005. People were at risk of being deprived of their liberty because legal requirements and best practice guidelines were not always followed.

Interactions with people who lived at the service were poor, people were not responded to in a timely manner and staff members did not always understand individual's needs and preferences.

People's nutritional needs were not consistently being met, people were at risk of choking and had not been adequately assessed and monitored for the risk of malnutrition, dehydration and ability to swallow.

Is the service caring?

Inadequate

The service was not caring.

People's dignity was compromised. People did not always receive care that was appropriate for their needs.

Summary of findings

Staff were not fully aware of individual's needs and preferences, people were not treated in a person centred way.

People were not involved in the planning and delivery of care. Staff supported people without communicating to them or helping them to understand what was about to happen.

People did not have access to advocacy information.

People were not always supported to maintain their independence and sense of person hood.

Is the service responsive?

Inadequate 

The service is not responsive.

Planning and delivery of care was not person centred.

The processes in place to make sure people's health and social care needs were properly assessed and planned were inappropriate and ineffective.

The service failed to respond to peoples changing needs by ensuring amended plans of care were put in place.

Liaison with other health care professionals was poor.

People were not always supported to engage in meaningful activities and were isolated from society.

Is the service well-led?

Inadequate 

The service was not well led.

The processes in place to make sure that the quality of service was assessed and monitored to ensure people received safe and appropriate care were not robust and were ineffective.

Staff told us that they was not supported by the previous management team and this had significantly contributed to deterioration in care standards.

Hazel House Care Home

Detailed findings

Background to this inspection

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

This inspection took place across two dates 14 & 15 July 2015 and was unannounced. We returned to the service at 23.00hrs on 14 July 2015 and undertook an unannounced night visit, our visit completed at 03.00am.

The inspection team consisted of two adult social care inspectors, a specialist advisor in dementia care and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert by experience had personal experience of caring for someone who has lived with dementia.

Prior to this inspection we looked at all the information we held about this service. We reviewed notifications of incidents that the provider had sent us since our last inspection and we asked local commissioners for their views about the service provided. We also requested feedback from community professionals, such as district nurses, the local Commissioning Group and social work professionals from adult safe guarding. Comments about this service are included throughout the report.

We have received on going communications from the provider, new manager and professionals within Lancashire County Council. We were told that the service was under continual contractual monitoring by Lancashire County Council since April 2015 and we received minutes from safe guarding strategy meetings held to discuss organisational concern. Minutes from a safeguarding meeting in July 2015 showed that the service was making improvements in line with the action plan set by the local authority.

The day before the inspection we received information of concern that we have communicated to the local authority safeguarding team for investigation. We used the information from this concern to focus on some specific areas during this inspection.

We engaged with all the people who lived at the service, however feedback was variable due to some people living with dementia being unable to reliably communicate. We spoke with five relatives, seven care assistants, one domestic, two senior care assistants, training and governance manager, the manager, a representative of the provider and the nominated individual.

The nominated individual is employed as a director, manager or secretary of the organisation (i.e. they should be a senior person, with authority to speak on behalf of the organisation). They must also be in a position which carries responsibility for supervising the management of the carrying on of the regulated activity (i.e. they must be in a position to speak, authoritatively, on behalf of the organisation, about the way that the regulated activity is provided).

We looked at ten people's care records, staff duty rosters, three recruitment files, training records, management audits, medication records and quality assurance documents.

Inadequate

Is the service safe?

Our findings

Feedback from people living at the home was minimal due to limited communication abilities and advanced dementia care needs. However we asked all people who lived at the service "Do you feel safe?" and people told us, "I don't always feel safe, people (other service users) gang up on me", "You get your privacy invaded. A resident came into my room and left a nappy on the floor, she was shouting abuse and carrying on. I can look after myself", "There are always people around, that makes me feel safe" and "I feel relatively safe, I am not sure that all staff know that I am diabetic, sometimes I worry that they will not know me well enough if I am unwell".

We spoke with visiting relatives and variable feedback was received, one relative told us, "I think he is safe, I feel ok when I leave him but I am not always happy about staffing levels. I have come in many times and had to ask staff to change (name), staff just don't seem to notice" another relative told us, "I think mum is safe, but her money is not. There are massive discrepancies in personal allowance receipts".

We found during this inspection, from records we looked at that some staff had received training in the safeguarding of vulnerable adults. However new starters had not received safeguarding or adequate induction training to ensure that they understood what constitutes abuse and how to report abuse. Staff members we spoke with were able to explain the basic principles of protecting people from abuse, however when we looked at how this was put into practice, we saw that staff were not always carrying out safe care procedures, for example we observed unsafe handling of people who lived at the service on three occasions.

We looked at safeguarding notifications from the provider and information supplied by Lancashire County Council Safeguarding Team. We found that 27 safeguarding cases had been reported in the last twelve months; recurrent themes were reported by staff, visiting professionals and relatives for example, inadequate standards of care and support, medicine errors, concerns about previous management attitude and response to people's concerns and staffing levels. The service was closely monitored by Lancashire County Council and they were given specific action plans to provide an opportunity for the home to improve. Minutes from a safeguarding meeting in July 2015 showed that the service was making improvements in line with the action plan set by the local authority, however despite continual support and oversight the service continued to fail to meet people's basic care needs, which led to organisational safeguarding concerns.

During our inspection we raised seven individual safeguarding alerts due to findings of inadequate care and support, five of the alerts were associated with inadequate management of people's nutrition and hydration, one alert was in response to information provided by a person living at the home, they told us that they were being restricted of independent living and had been told they were unable to visit their spouse, however we were unable to ascertain why this decision had been made. We raised one alert after finding a person in the night to be left without suitable night wear and bedding.

We also raised an organisational safeguarding alert regarding management of people's finances. The manager told us that significant discrepancies had been found when she initially did a cash audit at the service in June 2015. The service raised a safeguarding alert for one person who lived at the service in respect to financial abuse. A relative told us that they had grave concerns regarding how the service had managed his mother's personal allowance and explained that receipts did not reflect actual services provided. These concerns are being investigated by Lancashire County Council safeguarding team.

We found that reoccurring safeguarding alerts and whistleblowing themes were corroborated at the inspection, people did not always receive safe care and treatment. People's individual needs including personal hygiene and comfort were not always being met.

These shortfalls in safeguarding people from abuse and improper treatment amounted to a breach of regulation 13 (2) and (4) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found that people were not protected against avoidable harm or risk. Due to inappropriate systems at the home to assess and monitor people's health and social care needs we found that risks associated with every day care provision were compromised. Appropriate risk

assessments were not in place for people who lived at the home which placed people at risk of receiving care that was not appropriate for their needs and preferences to keep them safe.

As an example we saw that one person was hoisted, however their care plan did not provide information that would direct staff to provide safe care. Appropriate assessment of the person's mobility needs was not recorded and we were unable to find any information at the service that showed people had been suitably assessed for moving and handling equipment.

We asked staff how they would make a judgement regarding equipment use before supporting people to move and they told us, "I guess by looking at the persons size" and "I am not sure, I don't think I have ever questioned it, I just go off what others do". We found that people were at significant risk of harm due to inadequate systems in place to assess and monitor people's mobility requirements.

We looked at ten people's care records and found inadequate risk assessment, monitoring and care planning. Five care records had not been updated since October and December 2014. We looked at the provider's procedure for reviewing risk assessments and associated care planning and found that this was expected to be at minimum monthly or more regularly if required. The manager told us that she had updated 10 out of 27 care files since commencement in post in June 2015 and care records updated had not been reviewed since 2014. We found that the five care plans that had been updated did not clearly identify people's needs and associated risk factors.

For example we looked at a person's care file and found that their risk assessment for pressure damage was last updated in October 2014. The risk assessment stated that the person was at 'very high risk' of skin breakdown. We were unable to find a care plan that identified how the risk was to be managed. We observed the person for over three hours, they had restricted mobility and spent all of the time we observed sat in the same position, sleeping. Staff did not engage with the person, wake them for a drink, lunch or assist them move position.

We asked staff if the person needed to be assisted to change position and they told us "yes every two hours". We checked the person's care file and were unable to find any information regarding this need. Staff told us "(name) sleeps all day, we should move him every two hours but we haven't has change yet this morning".

We were informed by Lancashire County Council safeguarding team that four people living at Hazel House Care Home had developed significant grades of skin pressure damage in the last 12 months. Pressure sores can have a serious impact on a persons health and wellbeing. Two safeguarding investigations showed that allegations of neglect resulting in pressure sores had been substantiated.

We looked at training records and found that staff had not been trained in how to care for peoples skin and pressure damage prevention.

We asked staff if they feel confident to care for people with wounds. We were told "I know not to apply any dressings, but I wouldn't say I really understand how or why people get pressure sores" and "I think people get sore bottoms and heels here because we don't have slide sheets to move people in bed, it is difficult to help people change position so they are in the same position for long periods".

We looked at a person's care file and found that their falls risk assessment had not been reviewed since December 2014. We asked staff if the person was at risk of falling and they told us that the person spends all day sleeping then awake at night "pushing furniture around the lounge", so they would be at risk of falling or causing injury to themselves.

We were unable to find a care plan to reflect the person's nocturnal behaviours, or information regarding the risk of injury. We checked night records for the previous two months and found that the person had been awake at night consistently for that period of time, walking around the home and often moving heavy items of furniture. We were unable to find any information regarding recent medical review or liaison with the person's general practitioner so we asked the manager to ensure that a medical review was arranged as soon as possible.

The person's reversed sleep pattern put them at risk of malnutrition as they were recorded to have very little appetite during the day. There was also a further risk of falling or injury from moving furniture.

Inadequate

Is the service safe?

This lack of risk assessment and care planning amounted to a breach of regulation 12 (a) and (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Accident records were appropriately recorded and these were kept in line with data protection guidelines. This helped to ensure people's personal details were maintained in a confidential manner. The provider informed us, in the way of notification, when people had sustained serious injuries.

We looked at the safety and suitability of the premises. We found that the service had a distinctive malodour throughout and furniture in communal areas was old, staff told us that they believed some of the malodour issues were due to old lounge chairs that are now difficult to sanitise.

We found that the external garden areas were not secure and people living at Hazel House could freely access the garden from both lounge areas. We found that hazardous areas such as the sluice room and laundry were not secure. We asked the manager to respond to this concern on day one of the inspection.

The service did not have an employed maintenance worker. We looked at maintenance records and found that essential safety checks such as water temperatures and call bell system checks had not been undertaken since May 2015. We looked at the maintenance log book and found that job requests had not been responded to since January 2015. We raised five urgent maintenance repairs with the manager and provider on day one of the inspection, these included failure to change light bulbs in two WC areas and a non-operative shower room that was a safety risk and had not been secured. People were at increased risk of harm due to ineffective systems in place to ensure that the environment was safe and secure.

These shortfalls in the maintenance of premises safety amounted to a breach of regulation 15 (1) and (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We established that there was a sufficient number of staff on duty on the days of our inspection. However, the deployment of staff was not managed well, as we found the general environment to be disorganised without any structure or purpose to the day's activities. This meant that people did not have any meaningful structure to their day and supervision of communal areas was not always adequate. We observed people being left for a prolonged period of time and despite asking for support their needs were not always acknowledged.

For example, one person was observed to ask for the bathroom for over one hour, staff ignored the person until they nearly caused harm to themselves by attempting to self mobilise from their wheelchair and the expert by experience intervened to ensure that the person's needs were adequately met.

There was mixed feedback from relatives regarding staffing levels, one person told us, "Yes I think there are enough staff, although it would be nice to see staff sit and talk to the residents" and "I have spoken to the owner about staffing on several occasions. Sometimes there is only three staff on at night. Two staff are putting residents in bed leaving only one staff in the lounge, the owner still has not got back to me".

We looked at night time staffing rotas and training records and found that not all night shifts were covered by a senior care assistant who was deemed competent to administer medicines. We asked night staff what the procedure would be if someone requested pain relief at night time and we were told that they would have to wait until day staff come onto duty. We raised our concern immediately and gained reassurance from the provider that immediate action would be taken to ensure that all night shifts were covered by a senior worker competent to administer medicines.

We looked at three staff recruitment files. We found that the provider received disclosure and barring checks 'DBS' prior to employing people, these checks ensure that people working at the service do not pose a risk to vulnerable adults. We looked at employment reference systems and found that the provider failed to ensure that suitable checks were recorded. For example a new starter did not have any employment references in place. The manager told us that the providers recruitment policy stipulated that the applicants most recent employer should be approached for reference prior to offer of employment.

These shortfalls in safe and effective staffing amounted to a breach of regulation 18 (1) and (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service safe?

We looked at medicine management systems at the service. We found that medicine management systems were not robust, placing people at risk of not receiving their medicines as prescribed.

We carried out 17 random medicine stock checks and found that 11 medicines were in excess of the numbers recorded to have been administered. This showed us that on multiple occurrences people had not received their medicines as prescribed and staff had signed medicine records to reflect that medicines had been given.

We looked at medicine records for a person living at the service and found four occurrences in a period of ten days when staff recorded 'sleeping', the person's medicines were essential for their mental health and physical wellbeing. The senior carer told us that staff had failed to encourage the person to take their prescribed medicines and therefore they had become more restless at night time and slept all day. We looked at the person's care records and did not find evidence of referral's for medical review or any record of sleeping through medicine administration times.

We looked at a person's care plan who we observed to be experiencing pain. We saw that on admission to the service it was recorded that they were allergic to four different medicines. We saw that this person had no care plan relating to medicine management or any further information regarding their allergies. There was no information around management of pain relief or how the service was monitoring that pain relief was effective.

We looked at one person's daily notes. We saw that on 9th July 2015 staff had recorded that they had a 'very red' left hip and that 'cream was applied'. We also saw an entry on 10th July stating that cream had been applied to the 'bottom and hip'. We looked at this person's MAR records and saw no prescribed cream was recorded. We asked two separate staff about what cream was being applied to this person. Each member of staff told us the name of a different cream. We could not be assured that this person was receiving an appropriate topical medication that had been prescribed for them.

We observed that a tin of 'Thick and Easy' was left on the tea trolley that was accessible to residents. We removed this and gave it to the manager. This thickening agent is a risk to people if it is not prescribed to them if swallowed .

These shortfalls in the safe administration of medicines amounted to a breach of regulation 12 (1) and (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found that medicines were ordered in a timely manner, stored securely and the medicine room was clean and hygienic. We looked at how the service disposed of medicines and found that mid-cycle medicines needing disposal were not adequately recorded. We discussed this with the manager who agreed to take action.

We looked at storage and recording of controlled medicines and found that suitable systems were in place. We found insufficient systems in place for disposal of controlled medicines. We asked the manager to take necessary action to ensure that disposal systems were available for denaturing of controlled medicines.

The manager told us that she requested a pharmacy audit following intensive work undertaken to improve the safety of medicine administration at the service. A pharmacy audit was completed in June 2015 and this showed that improvements had been made. We found that changes made had not been fully sustained.

An infection control policy was in place, however we noticed that staff did not comply with safe procedures for the prevention and spread of infection and disease. We observed staff use personal protective equipment (PPE) whilst providing personal care and then fail to remove their PPE before leaving the area where intimate care was provided. This increased the risk of cross contamination of infectious disease.

We received information before the inspection of a safeguarding alert made by a visiting district nurse. Staff were reported to provide personal care for a person with an infection and did not wear protective clothing. During the inspection we had to advise staff on two occasions to protect themselves and others when we observed them carrying soiled incontinence products with bare hands.

We found that clinical waste management systems were inadequate, soiled waste was not being bagged before disposal and sluice areas were not secure. Laundry systems were not effective to prevent the spread of infection or disease, we saw that soiled personal linen

Inadequate

Is the service safe?

items were mixed with catering linen and meal time protective clothing. We observed staff carry soiled linen down the corridors without wearing protecting clothing placing themselves and others at risk of cross infection.

We looked at staff training around infection prevention and found that 14 staff had watched a training DVD, however work book assessments had not been marked therefore staff competency and understanding was not evidenced. New starters had not received suitable training.

We looked at the providers infection control audit, the audit was last completed in January 2015. An action plan was not completed following the audit to address shortfalls.

These shortfalls in infection control and prevention amounted to a breach of regulation 12 (1) and (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service effective?

Our findings

We asked people who lived at the service if they felt staff were competent and suitably trained to meet their needs, feedback varied; “They seem to know what they are doing, I do think they get training” and " I don't think the young staff, ones who have started this year know right from wrong, they were thrown in the deep end".

A relative told us "I worry about (relative) sleeping at night and his legs are very swollen. The district nurse has asked for (relative) to be put in a recliner chair as he has to have his legs up, she said (relative) should lie on the bed in the afternoons with his legs raised, none of this has happened. They don’t seem to understand his needs. They have no idea about dementia and how to care for people with dementia".

We looked at staff training and supervision records and found insufficient evidence of robust systems to ensure that staff are suitably trained and supervised. We looked at two newly employed care assistants training files and found that they had not been suitably inducted. We spoke with a mixture of staff at different grades and they told us "no, I have never had an induction", "training is no good, the DVD's are not interactive enough" and "I feel supported by the new manager, but before she came it was awful, the last temporary manager was a bully".

We found that the new manager had started to invite staff for one to one supervision meetings, however records showed that staff had not been supervised or received appraisals in line with the providers policy and procedure.

These shortfalls in staffing requirements amounted to a breach of regulation 18 (1) and (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Care Quality Commission (CQC) is required by law to monitor the operation of Deprivation of Liberty Safeguards. We discussed the requirements of the Mental Capacity Act (MCA) 2005 and the associated Deprivation of Liberty Safeguards (DoLS), with the manager. The Mental Capacity Act 2005 (MCA) is legislation designed to protect people who are unable to make decisions for themselves and to ensure that any decisions are made in people’s best interests. Deprivation of Liberty Safeguards (DoLS) are part of this legislation and ensures where someone may be deprived of their liberty, the least restrictive option is taken.

A person living at the service informed us that he had been denied freedom to leave the home to visit their spouse, we asked the manager if she was aware of this and she explained that the person's relative had made contact regarding the situation however the manager was unable to explain what actions or investigations had been implemented. We felt it necessary to alert Lancashire County Council Safe guarding team and requested an urgent review to ensure that the person was not unlawfully being deprived of their liberty.

We asked three staff members about deprivation of liberty safeguards (DoLS). None of the staff members we spoke to understood what this meant and were not aware if any people using the service were subject of a DoLS order. We saw one care plan with a completed DoLS application in place that was agreed by the local authority.

We looked at a care plans for a person who had schizophrenia and dementia. We saw these care plans had been put in place in July 2015. We saw that a capacity care plan was in place that told us the person “lacks capacity to make choices and decisions”. The plan did not detail what these choices or decisions were and we could not see any evidence of decision specific capacity assessments being completed. We saw that only very basic information was contained within the care plan around management of this person’s mental health.

We saw a ‘mental capacity assessment’ within another care plan. This was completed in 2013 and was very generic. It was not decision specific. We saw that this assessment concluded that the person lacked capacity but no additional information was contained with their care plans to show how this person could be supported to make decisions.

We saw two care plans that contained a ‘consent to give medicines’ form. We saw that family members had signed these forms without the service checking if the person who was receiving the medicine could consent for themselves.

We looked at training records and found that staff had not been provided training to help them understand the principles of the Mental Capacity Act 2005.

These shortfalls in consent to care and treatment amounted to a breach of regulation 11 (1) (2) (3) (4) (5) and regulation 13 (5) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service effective?

We asked people who lived at the service how they found the quality of food provided and if they felt enough choice was available.

People told us, "We just get what is put in front of us no, choice. If you don't like it you leave it. We only get porridge, cereal and toast every day. Never a cooked breakfast", "No choice, its not healthy food, no fruit always frozen veg. I would eat salad every day If I could. At tea time its cheese or paste sandwiches and Angel delight. I am diabetic. I am only offered yogurts for pudding or cheese, sometimes grapes", "The food varies from not so good to dreadful, there is always plenty of it. I am not saying I always like it. Like today lunch was tasteless. Never any choice" and "We have tea at about 4.30pm we get nothing after that till we have our breakfast at 9am. We do get a hot drink about 8pm but only occasionally we get half a toasted teacake or some toast but not always".

We observed the morning drink round at 10:50 am in the main lounge. We saw that people were not offered choices of drinks and no snacks were available. We saw that staff made communal cups of milky tea and then distributed these out.

We observed one person drink her cup of tea very quickly. This person told us she was very thirsty. We saw that staff did not provide this person with a second cup of tea when she was indicating that she wanted one. We had to intervene to get this person an additional drink.

We observed a person get his cup of tea in a plastic beaker with adapted handles. We saw that this person could not drink independently from this beaker and that the beaker was resting on his chest. We saw that an hour after he had been given the drink a staff member go over to him and say, "That tea must be cold" and then walk away. Half an hour after this the same member of staff returned and again said that the tea must be cold. The staff member then helped the resident to drink the tea which she had identified as cold. We observed the same person in the afternoon with a beaker of tea again resting on his chest. He was not being assisted by staff to drink.

We asked staff to show us the fluid charts for a person living at the service who needed support with eating and drinking. We looked at fluid records from 1st May 2015. We saw that some days a record was not in place. We saw other records that were not dated and we couldn't be sure when these were completed.

We saw twelve records from 1st May to 30th May 2015. Nine of these records showed that the person had received less than 500mls of fluid in a 24 hour period. We saw records that were as low as 70mls for a day. We saw thirteen records from 1st June to 12th July 2015. Four of these records showed the person had received less than 500mls of fluid in a 24 hour period. None of the records that we saw showed this person had received the recommended daily fluid intake of 1500mls.

We looked at this persons care plan. The plan had not been updated since December 2014. We saw that the care plan stated that the person needed 'soft textured diet and was not a choke risk'. We spoke to a member of staff who told us that this person was at risk of choking and required a pureed diet.

We saw this person did not have a nutritional risk assessment in place to highlight any of these risks. We saw that this person was last weighed in December 2014 and had lost weight in the previous months. We could not see that the service had sought advice from a dietician.

We observed that people had no access to fluids unless it was during a meal or tea round. We visited on a very warm day and had to suggest to staff that people be offered additional fluids. We could not be assured that people using the service were adequately hydrated.

We observed lunch time meal service. The dining area was chaotic. We observed people push their meal away and two people walked away without eating. We asked people if they enjoyed their lunch we were told "not really, it is bland" and "it was ok, nothing special". A choice of meal was not offered. We saw one person receive their meal and then push it away, when we asked them if they would like an alternative the person told us that they were a vegetarian and unable to eat the shepherds pie given to them, we asked staff if they were aware of this person's preferences and they told us, "yes sorry I forgot".

We looked at training records and found that staff had not received training around nutrition and hydration. We spoke with staff and asked them if they understood people's individual needs and if they could rely on care plan detail to find out people's needs and associated nutritional risks. We were told "the care plans are really out of date, so I wouldn't go off what they say", "I find people get different meal types depending on what staff are on" and "there is always plenty of food, but the quality is poor".

Inadequate

Is the service effective?

We spoke with the cook who had been in post for two days. We found that the cook did not have any experience of the care home sector or specific training around older adults and nutritional risks. The cook told us that they were not provided a list of people's dietary needs and they had no understanding of texturised diets and/or food fortification.

We raised safeguarding alerts for people we found to be at risk of malnutrition and or choking and informed Lancashire County Council safeguarding team that we believed this inadequacy was endemic throughout the service..

These shortfalls in meeting people's nutritional and hydration needs amounted to a breach of regulation 14 (1) (2) (3) (4) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service had basic directional signage to help people living with dementia find their way around the building. Personalised door signage was in place on all bedrooms.

Inadequate

Is the service caring?

Our findings

We asked people if the staff team were caring. People told us, "They are all very good, they do a very hard job and they are rushed off their feet", "Yes I think they are all very nice" and "most staff are kind, some always seem in a rush".

We asked people living at the service if they felt their dignity was respected one person told us, "I go and get a bath when I want to but people walk in on me there is no lock on the door. I walked in on a lady sat on the toilet yesterday, It's not very nice" another person said, "generally staff are respectful, some don't always ask before they do something".

We observed people's dignity be compromised throughout the inspection. For example we had to ask why two gentlemen were wearing bed clothes during the day, we asked if this was their choice. We were told that the laundry had lost one person's clothes and the other person did not have any clean clothes.

We spoke with people who live at the service and relatives and were informed that the laundry system was poor, people were often found by their relatives to be wearing other peoples clothes and we were informed by four people that their clothes have been lost.

We observed people being left in soiled clothing. During our night visit we found people in an undignified manner, left for prolonged periods in the lounge area. We asked the manager to take immediate action to ensure the people affected were provided person centred care immediately.

We observed a person in the lounge area to shout out to staff that they needed to use the toilet. We saw that three staff were in the lounge and that this request was ignored. We saw that this person needed to use a wheelchair and was trying to put himself into a chair that was close by. We saw that one staff member went over and said, "you don't go to the toilet as you have a catheter". This was not done in a dignified manner. The person continued to ask to go to the toilet for an hour. We saw another staff member tell the person, "You will have to wait, staff are on their break".

The person was eventually put into a wheelchair by staff but taken into the dining room. The person told us, "I don't know what they hell they are doing, look, off they go. They drive me round the bend". The person told us that being ignored happens on a regular basis.

We observed a different person ask to go to the toilet. We saw staff ask, "are you sure you really want to go?" We saw staff put this person in a wheelchair and leave them in the lounge. We saw that the person waited a further half an hour before anyone took him to the toilet.

We observed that one person in the lounge had very dirty teeth. We saw that this person had no care plan around oral care.

We also noticed that three people in the lounge had long and dirty fingernails. We looked at personal hygiene records for six people living at the service. We found that staff were not always completing these records. We found one person who had not had a bath or shower for three months and three people who had not had a bath or shower for two months. The other records we looked at showed sporadic baths and showers were given. On the day of our visit we found the service did not have a functioning shower as it was out of order. We spoke to one member of staff who told us "I have only bathed two people since I have started work here two months ago".

We found that the new manager had implemented a bath rota. However when we looked at these records we found that people were still not having a bath on a regular basis. Some people's names were not on the rota. We were concerned that this type of planned care did not give people a choice.

We looked at care records for 10 people and found that people were not involved in the care planning process. We asked people if they had been given the opportunity to be involved in writing their care plans and one person told us, "I was not aware I had a care plan, I would like to see it though".

We did not find any evidence of involving people who live at the service in decisions made about the general running of the home. We asked the manager if resident meetings were held and she explained that meetings were now scheduled, however she was unable to evidence when the last meeting was held prior to her employment.

We asked people if they knew how to access advocacy services, people told us that they did not have access to this kind of information. We looked around the home and did not see any literature that would assist people in making independent decisions.

Inadequate

Is the service caring?

These failings to provide dignified care that respected people's autonomy and independence amounted to a breach of regulation 10 (1) (2) of the Health and Social Care Act 2008 (regulated Activities) Regulations 2014.

Inadequate

Is the service responsive?

Our findings

We asked people who lived at the service if they felt their needs and wishes were responded to. People told us, "Staff never have time to chat, they are not interested in how I feel. If I don't like what is going on like at tea time when a lot of the residents start kicking off I just go to my room to get out of the way. What else can I do?", "Conversations like that never happen. I constantly ask when do you think I will be ready to go home it makes me feel at bit uneasy, when staff do not respond" and "I never get asked if I need or want anything, most of the time the staff will respond but sometimes I have to ask a few times".

We were also informed by a person living at the service that their mail was opened by staff on a regular basis, this was against their wishes. The person told us that they had missed a hospital appointment the day before because the letter was not given to them and no one had arranged transport. The person was distressed that this appointment was missed and felt that the booked procedure was very important. We asked the manager what action had been taken and she was not aware of the situation.

We asked relatives if they felt their loved ones needs and wishes were responded to. A relative told us "50% of the time yes, just depends who is on shift. The new manager is a lot more involved".

We looked at six care plans in whole at the service. We saw that three had been updated recently by the new manager. We saw that one of these plans was for a person who exhibited some behaviours that challenge. We saw that a record of these incidents was in place but was not always being completed. We saw that the last entry was on 5th June 2015, however we could see from daily records that other incidents had occurred following this entry. We also saw that this person had a falls risk assessment in place from 7th July 2015. This recorded that the person was at 'very high risk'. A second assessment for falls was also in the plan that showed only a 'high risk' as its outcome. We could not be sure which was correct.

We looked at how the service provided person centred care. We found little evidence of person centred care planning and out of the 27 people living at the service, 16 care plans had not been updated since October and December 2014. This meant that these people were at risk of receiving unsafe or inadequate care and support.

The manager told us that since she was appointed at the service her time has been spent "fire fighting" everyday issues including staffing and safeguarding investigations. The manager told us that care plans yet to be updated did not reflect people's needs.

We looked at three care files that had been updated and found that they still did not reflect people's current needs. For example, one person's care plans were written in July 2015 and they did not reflect the person's preferences and wishes around leaving the home to visit their spouse. This was a significant need for the person and was causing them distress, however the service failed to adequately assess and plan the person's care in accordance with their individual rights and choices.

We looked at one plan for a person who had seven recent entries in the 'challenging behaviour record'. Four of these where recorded physical altercations against other residents. We could not see evidence that the service had actively risk assessed and care planned to support the person in a person centred way. We looked at this person's care plan and saw that they were living with dementia. Their care plan only consisted of three plans, one for moving and handling, one for falls and another for sleep. These had last been reviewed in May 2015. We saw that this person had no care plan around their behaviours that challenge, their pressure area care, their medications, their eating and drinking, their personal hygiene or their social support. We observed that this person had a wound to their leg and sat on a special pressure area cushion.

We observed this person struggling to get up from their seat in the lounge. We saw staff needed to assist them with their mobility. When we checked the care plan it told us that the person was independently mobile. We saw that this person had a record of a 'very high falls risk'. This assessment had not been reviewed since February 2015.

We asked staff how they dealt with a person's behaviour that challenges. Staff were not clear how to provide support to this person when they became agitated. One

Inadequate

Is the service responsive?

staff member told us, “we take her to her room to calm down, that’s all we can do”. Staff told us they had not received training on dementia care or challenging behaviour.

We observed how staff responded to peoples care and support requests whilst sat in the main lounge area; we saw people ask for the toilet, for support to move and for extra drinks and staff were not always responsive to peoples requests.

We observed that the conservatory area attached to the main lounge was being shampooed. We saw that this started at 9am and finished at 11:15. The noise from this equipment was loud and was disturbing people using the lounge area. We saw one person sat with their fingers in their ears. One person told us, “It’s too noisy” another said, “I want them to turn it off”. We saw that during this time the noise from the equipment drowned out the television. This negatively impacted on people's wellbeing and staff did not acknowledge that people sitting in the conservatory area were distressed by the noise and they did not offer people an alternative place to sit.

We observed the main lounge area from 9am until 12:30pm. We saw that there was very little interaction from staff with people living at the service. We saw staff stand around watching television and speaking amongst themselves. We saw that a large amount of the people slept during the morning as they were not socially stimulated.

We asked people how they spend their day, people told us, "I spend my day sitting in a chair. I don’t like watching TV with other residents they don’t watch the programs I would like to watch. Hopefully I will be able to go home soon” and "Boring nothing to do. No newspapers, books or magazines. I stay in my room a lot of the time. I have nothing in common with most of the other residents".

These short falls in the delivery of person centred care amounted to a breach of regulation 9 (1) (2) (3) (4) (5) (6) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

We asked people who lived at the service if they would be able to speak with the manager about any concerns. People told us, "yes, she is very kind and understanding" and "I feel more comfortable now she is here".

We asked visiting relatives if they felt confident in the management team and able to report their concerns and we were told that people have a lot of faith in the new manager, however two people raised concern about the provider and said that they feel their concerns had been ignored. We discussed this with the nominated individual and they confirmed that complaint letters had been received and they intended to respond within the time scale indicated in acknowledgment letters that had been issued.

We found that the service had inadequate systems in place to ensure the delivery of high quality care. During the inspection we identified failings in a number of areas.

These included person centred care, medicine management, premises safety, managing risk to people and nutrition/hydration. These issues had not been sufficiently identified or managed by the provider prior to our visit which showed that there was a lack of robust quality assurance systems in place.

The provider employs an independent quality auditor who was onsite during day one of the inspection. We asked if this person had identified the same areas of risk we had highlighted and we were informed that audits were ad hoc and had not been done for some time.

We asked to look at recent audits undertaken at the service and found that core audits such as medicines and infection control had not been undertaken since January 2015. The manager was new in post and was unable to locate historical audits.

The manager showed us a pharmacy audit that has been completed by the community pharmacist in June 2015.

The provider had policies and procedures in place that covered all areas of health and social care. We asked staff if they had opportunity to read and understand the policies and we were told that staff did not have time. We spoke with two new starters, they told us that they had not been orientated to where the policies were stored and had not been given time to read policies that may assist them with performing their role and responsibilities.

None of the care and support systems in the home were based on current best practice. The home was disorganised and we found that there were no clear lines of responsibility.

These shortfalls in quality assurance amounted to a breach of regulation 17 (1) and (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service had a significant turnover of staff in 2014/2015, we were told that 33 care workers had left the home in the last 12 months. The service did not have key staff employed such as an administrator and maintenance worker, we were informed that these staff members had recently resigned.

We could see that the new manager was trying to improve standards and had started to regularly schedule resident, relative and staff meetings. The manager explained that every day was overcome by "fire fighting" on going issues, staffing problems and she recognised that the level of risk at the service was high.

During our inspection we established that the location is extremely busy, with the telephone constantly ringing and people regularly visiting. We felt that this put extra pressure on the manager and took her away from focusing on risk management. A second manager had been commissioned by the provider to assist with making improvements at the service; however they were not available during the inspection.

The manager was transparent in her way of working and was noticed to work in partnership with external professionals.

We found that the provider had not been responsive to known risks at the service.

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 The provider did not have effective arrangements in place to ensure that the care and treatment of service users was appropriate, outlined to meet their needs and reflected their preferences. Regulation 9 (1) (a) (b) (3) (a).

The enforcement action we took:
As the overall rating for this service is Inadequate, we have decided that the service will be placed into special measures. Where we have identified a breach of regulation during inspection which is more serious, we will make sure action is taken. We will report on any action when it is complete.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect The provider did not have suitable arrangements in place to ensure that people are treated with dignity and respect. Regulation 10 (1).

The enforcement action we took:
As the overall rating for this service is Inadequate, we have decided that the service will be placed into special measures. Where we have identified a breach of regulation during inspection which is more serious, we will make sure action is taken. We will report on any action when it is complete.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent Regulation 11 HSCA (RA) Regulations 2014 Need for consent he provider did not have suitable arrangements in place to ensure that the treatment of service users was provided with the consent of the relevant person in accordance with the Mental Capacity Act 2005. Regulation 11 (1) (2) (3).

This section is primarily information for the provider

Enforcement actions

The enforcement action we took:
As the overall rating for this service is Inadequate, we have decided that the service will be placed into special measures. Where we have identified a breach of regulation during inspection which is more serious, we will make sure action is taken. We will report on any action when it is complete.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment** **The provider did not have suitable arrangements in place to make sure that care and treatment was provided in a safe way for service users.** **Regulation 12 (1) (2) (a) (b) (c) (d) (g).**

The enforcement action we took:
As the overall rating for this service is Inadequate, we have decided that the service will be placed into special measures. Where we have identified a breach of regulation during inspection which is more serious, we will make sure action is taken. We will report on any action when it is complete.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **The provider did not have suitable arrangements in place to protect service users from abuse and improper treatment. Regulation 13 (1) (2) (3) (5).**

The enforcement action we took:
As the overall rating for this service is Inadequate, we have decided that the service will be placed into special measures. Where we have identified a breach of regulation during inspection which is more serious, we will make sure action is taken. We will report on any action when it is complete.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs **The provider did not have suitable arrangements in place to protect service users from malnutrition, risk of choking and dehydration.**

This section is primarily information for the provider

Enforcement actions

	Regulation 14 (1) (2) (3) (4)

The enforcement action we took:
As the overall rating for this service is Inadequate, we have decided that the service will be placed into special measures. Where we have identified a breach of regulation during inspection which is more serious, we will make sure action is taken. We will report on any action when it is complete.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment The provider did not have suitable arrangements in place to ensure that the premises were clean, suitable for the purpose which they are being used and properly maintained. Regulation 15 (1) (a) (c) (e) (2).

The enforcement action we took:
As the overall rating for this service is Inadequate, we have decided that the service will be placed into special measures. Where we have identified a breach of regulation during inspection which is more serious, we will make sure action is taken. We will report on any action when it is complete.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider did not have suitable systems in place to establish effective assessment, monitoring and improvement of the service. Regulation 17 (1) (2) (a) (b) (c) (e) (f).

The enforcement action we took:
As the overall rating for this service is Inadequate, we have decided that the service will be placed into special measures. Where we have identified a breach of regulation during inspection which is more serious, we will make sure action is taken. We will report on any action when it is complete.

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

This section is primarily information for the provider

Enforcement actions

The provider did not have sufficient numbers of suitably qualified, competent, skilled and experienced persons deployed in order to meet the needs of people at the service.

Regulation 18 (1) (2) (a) (b).

The enforcement action we took:

As the overall rating for this service is Inadequate, we have decided that the service will be placed into special measures. Where we have identified a breach of regulation during inspection which is more serious, we will make sure action is taken. We will report on any action when it is complete.