Amocura Ltd

Haddon Court Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We carried out this inspection on 22 September 2016. The inspection was unannounced. This meant no-one at the service knew that we were planning to visit.

Haddon Court was last inspected by CQC on 15 September 2014 and was compliant with the regulations in force at that time.

Haddon Court is a nursing home registered for up to 80 people situated within Beighton Village, approximately five miles from the city centre of Sheffield. The home is within easy access of the local community, which has a selection of shops and churches. Haddon Court is a large purpose built three-storey care home. It provides nursing and personal care for older people who have a physical disability, nursing needs or are living with dementia. The provider has temporarily closed the top floor of this service to focus on supporting people living with dementia. There were 53 people living at Haddon Court at the time of our inspection.

There was a manager at the service who was registered with CQC. 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.

People told us they liked living at Haddon Court and they felt safe there. Relatives said they felt their family member was safe at Haddon Court.

All staff understood what it meant to protect people from abuse. They told us they were confident any concerns they raised would be taken seriously by management.

Not all medicines were stored safely. We found gaps in medication administration records which meant people may not have always have been given their medicines at the right time. Medication administration records were not regularly audited to check that medicines were given to people as prescribed.

People's care records included risk assessments; however some contained gaps in recording information, and others were incorrectly completed. This meant staff didn't always have all the necessary information required to meet people's needs as safely as possible.

Care staff we spoke with had received training on understanding the Mental Capacity Act (MCA) and were able to give examples of what this meant in practice.

Care records did not reflect whether a person had capacity to make decisions about their care and treatment. The registered manager had referred everyone living at Haddon Court for a Deprivation of Liberty Safeguards (DoLS) authorisation. This blanket approach was not necessary and meant they may not have

fully understood their responsibilities with regard to the MCA.

Staff were provided with appropriate training, regular supervisions and an annual appraisal to ensure they were suitable for their job and supported in their role.

We saw people had access to external health professionals and this was evidenced in people's care records.

People living at Haddon Court and their relatives told us staff were caring and supportive. We saw and heard positive interactions between people and staff.

People told us they enjoyed the variety of food and drinks available to them. We saw there were different options available at mealtimes, and drinks and snacks were made available throughout the day.

People living at Haddon Court and staff working there, told us the registered manager was approachable and responsive to any concerns they had.

The service had up to date policies and procedures which reflected current legislation and good practice guidance.

There were no records of any meetings with people, their relatives or staff. This meant that although people and staff may have been asked for their views, their responses were not recorded and therefore not necessarily acted on. There was evidence of regular quality audits being undertaken. However, there was no record of any actions to be taken as a result. In addition in some audits we saw areas had been ticked as compliant but this did not correlate with what we found.

During our inspection, we found five breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, relating to safeguarding service users from abuse and improper treatment, safe care and treatment, fit and proper persons employed, need for consent, and good governance.
You can see what action we told the provider to take at the back of the full version of the report.

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 always safe.

Medicines were not always stored safely or administered when they should be.

Safe recruitment procedures were not always followed.

People's care records contained risk assessments; however some contained gaps in recording information, and others were incorrectly completed.

Staffing levels were appropriate to meet the needs of people who lived at Haddon Court.

People living at Haddon Court and their relatives told us they felt the service was safe.

Is the service effective?

Requires Improvement

The service was not always effective.

Care records did not reflect whether a person had capacity to make decisions about their care and treatment. The registered manager had unnecessarily referred everyone living at Haddon Court for a DoLS authorisation.

Staff received regular supervisions, annual appraisals and appropriate training to support them to carry out their jobs effectively.

People were offered a variety of options to meet their nutritional and hydration needs. People living at Haddon Court told us they enjoyed the food and drinks on offer.

Is the service caring?

Good

The service was caring.

People living at Haddon Court and their relatives told us the staff were caring.

Staff knew what it meant to treat people with dignity and respect.

Staff spoke with affection and a good knowledge about the people they supported. They knew people's preferences and social histories.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care records had gaps in recording information and where information was recorded it did not always accurately reflect the person's current level of need.

There were organised activities available to people living at Haddon Court on weekdays. Some people and their relatives told us they would like more activities.

There was an up to date complaints policy and procedure in place, but no overall record kept to identify any trends.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The views of people living at Haddon Court and staff working there were not regularly obtained and were not recorded.

There was evidence of regular quality audits being undertaken. However, there was no record of any actions to be taken as a result.

The service held up to date policies and procedures which reflected current legislation and good practice guidance.

People living at Haddon Court and staff working there told us the registered manager and the management team were approachable and supportive.

Haddon Court Nursing Home

Detailed findings

Background to this inspection

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

This inspection took place on 22 September 2016 and was unannounced. The inspection team was made up of two adult social care inspectors, one pharmacist specialist inspector and one 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.

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.

Prior to the inspection we reviewed the information we held about the service, which included correspondence we had received and any notifications submitted to us by the service. A notification must be sent to the Care Quality Commission every time a significant incident has taken place, for example where a person who uses the service experiences a serious injury.

Before our inspection we contacted staff at Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. They told us they had received two negative comments about Haddon Court in the previous five months. We also contacted members of Sheffield City Council contracts and commissioning service and the NHS Sheffield Clinical Commissioning Group. They told us they had been jointly monitoring the service and trying to support the provider to improve as they had concerns regarding the quality of support provided to people who used the service.

During the inspection we spoke with six people who lived at Haddon Court and eight relatives who were visiting. We spoke with five visiting professionals. We met with the registered manager and nominated individual. We spoke with an additional ten members of staff. We spent time looking at written records, which included four people's care records, six staff files and other records relating to the management of the service. We checked the medication administration records for eight people.

Inadequate

Is the service safe?

Our findings

Relatives told us they felt their family member was safe living at Haddon Court. Comments included, "[Name] is really happy here and I am very pleased, yes [Name] is safe," "The ladies in the office are always very courteous when I ring, I am quite happy that [Name] is safe here."

We saw the service had an up to date safeguarding policy and a whistleblowing policy. Whistleblowing is when a member of staff raises a concern about wrongdoing at their place of work. Staff we spoke with knew this and were confident any concerns they had would be taken seriously by management. Staff told us they had received training in safeguarding vulnerable adults from abuse. The training records we were shown confirmed that 58% of staff had completed mandatory safeguarding refresher training and for the rest this training was overdue. All staff we spoke with were able to tell us what abuse was and how they would recognise it. Again they were confident their concerns would be taken seriously by management.

During the previous 12 months the service had notified CQC of six safeguarding alerts they had raised with the local authority. These were all regarding alleged physical or sexual assaults of people living at Haddon Court by another person living there. Five of the six were regarding one person in particular who had a high level of need which could sometimes result in behaviours that may challenge. This was recognised by the registered manager and a more suitable, alternative place to live had been found for this person. We talked to the registered manager about any lessons they had learnt as a result of these incidents and they told us they would be more thorough when undertaking pre admission assessments of people considering moving to Haddon Court.

CQC were aware of a further two safeguarding concerns raised with the local authority. The family of a person living at Haddon Court referred an unexplained injury to their relative. The registered manager investigated and as a result the member of staff concerned was suspended. CQC also referred a number of allegations made by an anonymous whistleblower.

The registered manager showed us a file they kept which contained copies of all safeguarding concerns and this correlated with the information CQC had received. However, the outcome of each alert and any lessons learnt to improve the service as a result were not always recorded. We spoke to the registered manager about this who confirmed this was the case. As systems and processes were not in place to effectively investigate allegations or evidence of abuse this was a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, regulation 13, Safeguarding service users from improper abuse and treatment.

We checked whether medicines were stored safely and at the correct temperatures to ensure optimal effectiveness. We saw medicines were stored securely in locked treatment rooms and access was restricted to authorised staff. Unwanted medicines were disposed of in accordance with waste regulations. There were appropriate arrangements in place for the management of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse). They were stored in a controlled drugs cupboard, access to them was restricted and the keys held securely. We checked records

and saw evidence of regular balance checks being carried out.

Room temperatures where medicines were stored were recorded daily and were within safe limits. We checked medicines which required cold storage and found records did not comply with national guidance because only the current temperature had been recorded. The temperature of the fridge used for storing medicines should be within the NHS guidance of between 2 and 8 degrees Celsius. Temperatures had been recorded outside of the recommended range on the downstairs unit on seven occasions in August 2016 and two occasions in September 2016. No action had been taken by staff and the registered manager had not been informed. This meant we could not be sure these medicines were safe to use.

We checked whether people were given the correct prescribed medicines. We looked at Medication Administration Record (MAR) charts and observed a medicines administration round at lunchtime. We identified discrepancies in the recording of stock balances of medicines for four of the seven records we reviewed. One person's MAR chart had been handwritten; we found the dosage of two medicines had been incorrectly transcribed from a hospital discharge letter. A second check had been carried out by nursing staff to confirm the dosage instructions but this had failed to detect the errors. In addition, we identified a transcription error in the strength of another person's pain killers. We told the registered manager about this and they took immediate action to ensure the correct dosages were entered on the MAR charts.

The service did have a PRN policy but it did not contain any detailed guidance to enable care staff to safely administer medicines, which were prescribed to be given only as and when people required them. For example, one person was prescribed a medicine for agitation, but there was no information to indicate the behaviours this person might display which would mean the medicine should be given and there was no written guidance to support safe administration. This practice was not in accordance with the home's medicines policy which stated all PRN medicines should have an associated care plan. In addition, staff did not record the reasons for administration in the daily notes so it was not possible to tell whether these medicines had had the desired effect. Some medicines were prescribed with a variable dose, for example one or two tablets to be given. We saw the quantity given was not always recorded meaning that records did not accurately reflect the treatment people had received.

We checked whether people received their medicines at the correct time. One person was prescribed a pain relief patch which should have been changed once weekly. We found this had been missed for four days; staff had not recorded or reported the error and there was no documentation to assess or record the person's level of pain. This increases the risk of the person experiencing pain or discomfort.

Another person was prescribed two creams, which were applied by care staff. We checked application records and found one cream had not been applied in accordance with the directions on their MAR chart. Staff could not provide us with any application records for the second cream. Nursing staff signed the MAR to say creams had been applied by care staff. Nursing staff told us they did this without checking with the member of care staff or the application record sheets. This practice was not in accordance with the home's medicines policy and meant we could not be sure this person had received the creams as they had been prescribed.

Another person was prescribed a preventer inhaler to help with breathing which should have been given regularly twice each day. We checked their MAR chart and found only four doses had been given since the beginning of August 2016. The service's medicine policy stated regular refusal should be referred to the person's GP and a care plan put in place. We asked staff if the person's GP had been informed but no records had been made. This meant there was a risk the person's breathing may have deteriorated because they had not received their medicine as the doctor had prescribed.

The lack of proper and safe management of medicines was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Safe care and treatment.

We asked the registered manager how they calculated how many staff were required on each shift to meet the needs of the people who living at Haddon Court. The registered manager showed us a completed dependency assessment for each person living at Haddon Court, which they reviewed each month. The registered manager told us they then worked out staffing levels based on their past experience of doing this. We were told there were usually a senior carer and three care staff employed during the day on the residential unit on the lower ground floor. On the day of our inspection a care worker has rung in sick. An agency worker was called in to cover for this member of staff. On the ground floor where people with nursing needs resided the floor was split into two units. There was a nurse and three members of care staff for each unit. In addition the service employed two activity coordinators and a number of ancillary workers to meet people's domestic and nutritional needs.

On the day of our inspection we arrived early at Haddon Court while the night shift staff were still working. We saw there were two care staff and a nurse downstairs on the residential unit. On the ground floor nursing units there were four care staff and a nurse. These staffing levels matched with the rotas we saw. We saw there was a relaxed atmosphere, no one was being rushed. Two people were up and dressed downstairs and enjoying a hot drink. Care staff were aware of when people liked to get up and we saw throughout the morning people were given hot drinks and supported to get up and dressed, there were enough staff to meet people's needs. At times staff were busy, but no one was left waiting, call bells were answered promptly. People told us there was enough staff to meet their needs. Staff we spoke with agreed there was enough staff. One member of staff said, "There are enough domestic staff now the top floor is closed. There can be problems with numbers of care staff, but only if someone rings in sick."

Haddon Court is registered to accommodate 80 people. However, the provider had taken the decision to voluntarily close the top floor as they have been unable to recruit nursing staff. We were told the service had maintained similar staffing levels as to when there were three floors in operation and staff told us this was now much more manageable.

Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 requires certain information and documents to be obtained to demonstrate a thorough recruitment process has been followed to ensure fit and proper persons are employed. This includes evidence of a disclosure and barring (DBS) check taking place and satisfactory evidence of conduct in previous employment concerned with the provision of services relating to health or social care or children or vulnerable adults. Where a person has been previously employed in a position whose duties involved work with children or vulnerable adults, satisfactory verification, so far as reasonably practicable is required as to the reason why that person's employment ended.

Four of the six staff files we looked at contained all the information required to evidence that the service followed safe recruitment practices. However two did not contain satisfactory references. In addition these two files contained reference to a number of complaints about the members of staff concerned and a number of concerns they had raised about working at the service. The response to these concerns by the registered manager was inconsistent. We saw some issues were investigated and others were recorded but there was no further evidence the issues had been dealt with. Furthermore, where it was recorded that one person had been investigated and found to have been guilty of gross misconduct no further action had been taken by the service.

This was a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, regulation

19, Fit and proper persons employed.

The care records we looked at contained risk assessments. Some were completed with a lot of detail enabling care staff to identify the risk and what action to take to mitigate against it. However this was not always the case as some of the risk assessments we saw were incomplete with blank sections. In addition some were completed incorrectly, for example on person's level of risk of falls had been assessed as 19, but two sections of the form hadn't been completed. If they had their risk would have been higher with a score of 27. Improvements were required in this area.

The service kept an accident and incident log book. Any action taken was recorded in the log book. There was no overall analysis of the accidents and incidents recorded which would have identified any trends and any actions that could be taken to reduce the risk of them happening again.

The service was responsible for managing small amounts of money for most of the people living at Haddon Court. The service kept an individual financial record for each person and statements were sent to their relatives each month if requested. We checked the financial records and receipts for three people and found they detailed each transaction, the money deposited and the money withdrawn by the person. The records were signed and up to date. We were told the financial records were audited every month. This showed that procedures were followed to help protect people from financial abuse.

Requires Improvement

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes 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. There was a keypad code required to move between floors and another to access the main reception area where the front door was. This meant people's liberty at Haddon Court was potentially being restricted. The registered manager told us and we saw they had applied to the local authority for DoLS authorisations for everyone living at Haddon Court. This blanket approach indicated the registered manager may not have fully understood their responsibilities with regard to the MCA. Not everyone living at Haddon Court lacked capacity and therefore did not meet the criteria for a DoLS application. However, care staff we spoke with did have an understanding of the principles of the MCA and they were able to tell us what this meant in practice.

We looked at the care record for a person who was being administered medicines covertly, which meant they were disguised in the food or drink given to the person. In this case there was no record on file to show that appropriate assessments and records of decision-making had been recorded in accordance with the MCA. All the care records we looked at had capacity to consent forms for different decisions regarding the person's care and treatment. However, none of the care records we looked at had the forms fully completed.

As the registered provider wasn't acting in accordance with the MCA, and care and treatment wasn't always provided with the consent of the person this was a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, regulation 11, Need for consent.

The registered manager showed us the training matrix which listed the required training for all staff. The matrix was designed to show the date when the member of staff last undertook the training and if it was within timescales the date was flagged as green. Where the member of staff was overdue to undertake the training it was flagged as red. This was because some training needs to be completed more than once in order to keep up to date with current legislation and any innovations in practice, for example safe moving and handling techniques. We saw from the training matrix most staff had received mandatory training in understanding MCA and DoLS, where this was flagged red and therefore out of date we saw they had been booked to attend the training the following month.

Staff we spoke with confirmed they had regular training appropriate to their job roles and the staff files we

looked at confirmed the training had taken place. We saw records of an induction taking place for new starters to the service.

Supervision is regular, planned and recorded sessions between a staff member and their manager to discuss their work objectives and wellbeing. An appraisal is an annual meeting a staff member has with their manager to review their performance and identify their work objectives for the next twelve months. We were told by the registered manager that supervision should take place every two months. This was also stated in the service's supervision policy. Staff we spoke with told us they had regular supervisions and yearly appraisals. The staff files we looked at held written records of supervisions and appraisals taking place as often as they should.

This meant staff members were aware of their roles and responsibilities and had the relevant skills, knowledge and experience to support people living at Haddon Court.

We asked people what the food was like at Haddon Court, one person told us, "The food is nice, well we get two choices you see, I don't like foreign food but some do, it's very good. It's very nice here I like it."

We observed people having lunch in the main dining room on the ground floor; the room was bright and attractively decorated with art work and colourful curtains. Care staff began supporting people to sit in the dining room almost one hour before lunch was served and we saw this did cause some problems with people appearing bored and fidgeting. One person was shouting at people on the next table which did upset the people sitting there. This person did become less agitated when lunch arrived.

People were all given a choice of mixed grill or curry and staff supported people to decide what they wanted to eat. We saw there were sufficient care staff available during lunch time and everyone who needed assistance with eating was supported in a patient and unhurried manner. The food looked and smelled good and most people ate well, the people with poorer appetites were offered a different dish or more gravy/custard to encourage them to eat more.

We spoke with a member of kitchen staff who was aware of people likes and dislikes. They knew which people needed special diets, for example, those people at risk of choking who required a soft diet. We were told staff asked people after breakfast what they wanted for lunch but it wasn't a problem if they changed their mind as this could usually be accommodated. The member of kitchen staff confirmed there were two main meal choices and two dessert options offered at every lunch and tea time. In addition a person could have a cooked breakfast everyday if they wanted to, and sandwiches and snacks were available at supper time. We saw a selection of drinks, fruit and snacks were also offered throughout the day of our inspection.

This meant the nutritional and hydration needs of people living at Haddon Court were met.

Care records showed that people had access to a range of health and social care professionals. We spoke with five visiting professionals during our inspection and they were complimentary about the care provided at Haddon Court. A district nurse told us no one living at Haddon Court currently required pressure care and there were no current concerns regarding anyone losing weight. This was an indication staff were providing appropriate care and treatment to people. We were also told that there was really good communication from staff and the, 'Staff team were much more stable and knew residents really well.'

Good

Is the service caring?

Our findings

We spoke to a visiting relative who explained that their family member had previously lived in a different care home. They told us, "I think the care she has received in the two years she has been in here has been far superior to the old home." Comments from other relatives included, "I am very happy with this home it is not institutionalised like some homes, staff are very friendly and welcoming to me and take good care of [name of person]," and "They [staff] are on the ball, If [name of person] is not well they ring me and even if the doctors visiting they ask if I want to be there"

During our inspection we saw everyone living at Haddon Court was wearing clean clothes and were well presented. Two hairdressers visited during the day of our inspection and we saw care staff were gently supporting people to and from the hairdressing salon. The hairdressers told us the people they saw always had clean glasses, teeth and were appropriately dressed. People visiting the hairdressing salon were regularly offered drinks. We heard people talking happily together and enjoying a pampering experience.

We spoke to one of the people who was supported throughout the day to go outside to smoke a cigarette. They were happy and cheerful and told us, "I am very happy, they [staff] are great."

We saw there was positive interaction between people and all the staff working on both floors. Staff were friendly, attentive and polite, residents appeared relaxed in their company. We walked into a lounge on the ground floor and saw a nurse dancing with a person living at Haddon Court. They were both clearly enjoying themselves.

People had different preferences regarding personal care, one person liked a shower every morning and we were told these individual needs were met. Some people required to be cared for in bed and we asked relatives whether staff took the time required to support their family member. One relative told us, "I have observed the staff, they have worked with [name] for a long time and every time I come the nurse keeps me up to date with things if there are any problems or if they have noticed any changes, they had even explained about the change in food formulas," "They are amazing with [name] they have such respect and [name] is always clean you never get a smell," "I think [name] is safe and well cared for, I have no concerns about the care and now [name] condition has deteriorated they looked at ways that things could be improved, they have moved the bed so that [name] can look through the window and they suggested that I got a television."

Every member of staff we spoke with clearly knew people's likes and dislikes, and their social histories. They spoke fondly of the people they supported and we heard many joyful conversations. We asked staff to describe to us what treating people with dignity and respect meant to them. Staff were able to tell us they would close curtains and doors when supporting a person with their personal care. They would cover people with a towel to maintain their dignity. Staff told us they knock and wait before entering a person's room. Staff we spoke with told us they would be happy for a loved one to live at Haddon Court.

Requires Improvement

Is the service responsive?

Our findings

Care records we looked at contained some information regarding the person's life history and preferences. This wasn't always completed. None of the care records we looked at contained any evidence of the person and/or their relative being involved in reviews. The reviews that had taken place were often found to be recorded with only brief entries, for example 'no change, remains the same' with no further evidence of any discussions detailed in the care records. Not all the information we looked at correlated with what we observed. For example, one person was described as having 'full bowel control' and elsewhere in their care record it stated they were doubly incontinent. A relative we spoke with told us that they knew their relative had a care plan but they had never been involved.

As the service had not maintained an accurate, complete and contemporaneous record in respect of each service user this was a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, regulation 17, Good governance.

The service employed two activity coordinators working from Monday through to Friday. One was part time working during weekday afternoons and the other worked full time every weekday. This meant there weren't any organised activities over the weekends. One relative told us, "The only thing that could be better is activities and stimulation upstairs [ground floor], it's not the staffs fault but sometimes the activities people are called off onto other duties, I don't think that one outing and a singer four times a year is enough really. The home is dead at weekends."

We saw there was an activity timetable displayed in the main reception area. However this area could only be accessed by a key pad code and therefore the timetable was not readily accessible to people living at Haddon Court. We saw the activities included bingo and quizzes. On a Friday afternoon a matinee film performance was scheduled. This was held on the currently empty top floor which anyone living at Haddon Court could attend. We were told there was also a regular tea dance held at the neighbouring lifestyle centre. The service also undertook one day trip a year. The most recent being to Yorkshire Wildlife Park. Another relative told us, "They are doing activities all the time, [name] has made some lovely cards, they went to Yorkshire Wildlife Park and absolutely loved it."

We observed a card making activity in the morning and a bingo session in the afternoon, music was playing and being enjoyed in communal areas throughout the day of our inspection. One of the activity coordinators told us that bingo, dominoes and simple quizzes were the most popular activities, and that people living on the ground floor could be difficult to engage because they did seem to be asleep most of the time. We asked two people living on this floor if they engaged in any activities, they told us that they had dances and parties and they both liked the food.

We saw there was an up to date complaints policy and this was also on display in the reception area. This gave details of who to contact to make a complaint and who to contact if people were unhappy with the original response. Every one we spoke with knew who the registered manager was and said they wouldn't hesitate to complain if there was cause to.

In the PIR the registered manager stated there had been two complaints in the previous 12 months. We saw there was a complaint files and these complaints had been responded to. There was no overall analysis of the complaints to identify trends or any lessons learnt.

Requires Improvement

Is the service well-led?

Our findings

Every person we spoke with and their relatives knew who the registered manager was and wouldn't hesitate to contact them if they had any concerns. Staff we spoke with told us the registered manager was approachable and supportive.

We asked if people living at Haddon Court and the staff that worked there were asked for their views on the service provided and to make suggestions for improvement. Some services seek feedback through questionnaires and/or suggestion boxes. We were told yearly questionnaires were sent out to visiting professionals, relatives and staff. We didn't see any results or analysis of the responses. The registered manager told us the activity co-ordinators asked people living at Haddon Court for their views about the service.

The registered manager told us there was a relatives' meeting scheduled for every other month but these were poorly attended. No relatives we spoke with remembered being asked to complete any surveys or being invited to any relatives meetings, however most said they were kept informed and two relatives told us they were constantly being updated about their relative's care and treatment.This meant that although people and staff may have been asked for their views, their responses were not recorded and therefore not necessarily acted on.

We looked at the arrangements in place for quality assurance and governance. Quality assurance and governance processes are systems that help providers to assess the safety and quality of their services, ensuring they provide people with a good service and meet appropriate quality standards and legal obligations. The service undertook a number of monthly audits including medicines, infection control, health and safety, and care plans. It was not clear which member of staff had undertaken each audit or who was responsible for any actions required as a result of the audit. Where actions were identified there was no overall tracking to record any remedial actions taken. The medicines audits we looked at were tick boxes to confirm that different areas of compliance had been checked. We saw some areas had been ticked as compliant but this did not correlate with what we found. For example, 'Are PRN medicines recorded properly' was ticked yes for August. This was not what we found.

This meant that systems were not established and operated effectively to ensure compliance with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and was therefore a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Regulation 17, Good governance.

We reviewed the service's policy and procedure file, which was available to staff in the main office. A sheet with some staff names was attached to the file to confirm they had read and understood the contents. However it was not a complete list of all staff names and no member of staff had signed or dated the sheet next to their name. The file did contain a wide range of policies and procedures covering all areas of service provision relating to both people living at Haddon Court and the staff that worked there. We saw the policies and procedures were up to date and regularly reviewed. This meant they reflected current legislation and good practice guidance.

We checked the maintenance records for the premises and equipment were satisfactory and up to date. The service held records of up to date safety checks on small electrical items (PAT tests), equipment service and maintenance, gas safety and fire safety.

The registered manager was aware of their obligations for submitting notifications in line with the Health and Social Care Act 2008. The registered manager confirmed that all notifications required to be forwarded to CQC had been submitted. Evidence gathered prior to the inspection confirmed that a number of notifications had been 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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent The registered provider wasn't acting in accordance with the MCA, and care and treatment wasn't always provided with the consent of the person.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Systems and processes were not in place to effectively investigate allegations or evidence of abuse.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The service had not maintained an accurate, complete and contemporaneous record in respect of each service user. Systems were not established and operated effectively to ensure compliance with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Recruitment procedures were not always operated effectively. Disciplinary investigations

Treatment of disease, disorder or injury

were not undertaken consistently.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Diagnostic and screening procedures	There was a lack of proper and safe management of medicines.

The enforcement action we took:

W/N to be sent.