Nestor Primecare Services Limited

Hazelmere Extra Care Scheme

Inspection report

Hazelmere
Hambleton Way
Winsford
Cheshire
CW7 1TL

Tel: 01707254631

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We undertook a focused in inspection on the 24 January 2018 and 1 February 2018

Our last comprehensive inspection of Hazelmere Extra Care Scheme took place on the 13 and 14 March 2017 and the service was rated as Good.

Following that inspection we received concerns in relation to safe care and treatment and consent. As a result we undertook a focused inspection to look into those concerns.

This report only covers our findings in relation to those topics. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Hazelmere Extra Care Scheme on our website at www.cqc.org.uk.

The service provides care and support to people living in specialist 'extra care' housing. Extra care housing is purpose-built or adapted single household accommodation in a shared site or building. The accommodation here is bought or rented, and is the occupant's own home. People's care and housing are provided under separate contractual agreements. CQC does not regulate premises used for extra care housing; this inspection looked at people's personal care and support service.

Planned, day-to-day personal care can be provided by staff based at the site or from elsewhere, including ordinary domiciliary care agencies. There is a care provider based at the scheme able to provide emergency support to everyone living there. Not everyone living in extra care housing receives regulated personal care.

There are 106 apartments and also access to communal facilities such as a bistro, library, gym, laundry and an assisted bath room.

There was a registered manager. This 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 found the service had breached a number of regulations. You can see what action we told the provider to take at the back of the full version of the report.

The registered provider failed to identify, assess and manage risks to the health and safety of people of using the service. Medicines were not managed safely and some people did not get their medicines as required.

The provider did not have effective quality assurance processes to monitor the quality and safety of the service provided and to ensure that people received appropriate care and support.

Processes and procedures were in place to ensure people were protected from abuse and harm. Staff spoke about the actions they would take if they thought a person was at risk of harm. However, we found that not all concerns were reported and fully investigated.

People were not always supported to have maximum choice and control of their lives. Staff did not have a clear understanding of restrictive practices. There was a lack of documented evidence around a person's ability to make a decision or to make an unwise choice which may have put them at risk.

The service ensured trained staff were deployed to support people. The registered provider had a robust recruitment process in place, with staff being fully checked before starting working with people.

There were enough staff employed to carry out all the visits that were required. People told us they were regularly supported by the same team of care workers.

People were supported to maintain good health and access to healthcare professionals.

Feedback was regularly sought from people using the service and staff.

Staff said they felt supported by the management team. Staff we spoke with confirmed they could raise issues with the management and said they were "Approachable".

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Risks to people were not always identified and where risks had been recognised these were not fully mitigated against.

The service did not ensure medicines were administered safely and in line with the instructions on people's prescriptions.

Staff demonstrated a good awareness of safeguarding but incidents were not always reported.

Is the service effective?

Requires Improvement

The service was not always effective.

The registered provider had not completed Mental Capacity Assessments and 'best interests' decisions for people who may have lacked in mental capacity to make decisions for themselves.

Training, supervisions and appraisals were up to date and monitored by the service.

People were supported to maintain their diet and hydration.

Is the service well-led?

Requires Improvement

The service was not always well led.

The registered provider did not have effective quality assurance processes to monitor the quality and safety of the service provided and to ensure that people received appropriate care and support.

The service had a clear management structure in place. Staff said they were happy working at the scheme

People and staff were encouraged to express their views about the services.

Hazelmere Extra Care Scheme

Detailed findings

Background to this inspection

We undertook an unannounced focused inspection of Hazelmere Extra Care Scheme on 24 January 2018 and 1 February 2018. The team inspected the service against three of the five questions we ask about services: is the service safe, is the service effective and is the service well led.

No risks or concerns were identified in the remaining Key Questions through our on-going monitoring or during our inspection activity so we did not inspect them. The ratings from the previous comprehensive inspection for these Key Questions were included in calculating the overall rating in this inspection.

This inspection was prompted in part by notification of an incident following which a person using the service sustained a serious injury. The information shared with CQC about the incident indicated potential concerns about the management of risk of falls from moving and handling equipment, risk assessments and an understanding of capacity and consent to care and treatment.

Concerns had also been raised following the last inspection in regards to staffing levels, and the safe management of medicines. Therefore, this inspection also explored these aspects of current care and treatment..

Inspection site visit activity started on 24 January 2018 and ended on 1 February 2018. We visited the office location on the 24 January 2018 and 1 February 2018 to see the manager and office staff; and to review care records and policies and procedures.

The inspection was carried out by two adult social care inspectors.

Prior to the inspection, we reviewed information that we held about the service such as whistle blowing concerns, complaints, and compliments and safeguarding investigations. We also took note of notifications received from the service such as serious injuries and deaths.

During the inspection we looked at the records relating to the care and support of nine people who used the service: this included care plans, risk assessments and medication administration records. We also spoke to four people who used the service.

We also reviewed records in regards to staffing and the management of the service. This included three staff files, training records, and audits, meeting minutes, policies and procedures.

We spoke to the commissioners of the service who told us that they had no concerns about the service. We also spoke to the safeguarding unit to discuss the incident that prompted this inspection.

Requires Improvement

Is the service safe?

Our findings

Prior to the inspection we received information of concern in regards to the management of risk and falls from moving and handling equipment.

People we spoke with told us that they felt safe and had no concerns over the care that they received.

Some people were supported by staff with aspects of their medication management such as its ordering, storage or administration. We found that this was not safe.

There were occasions on which people had not received their medication as required. This was because they were not available despite staff having the responsibility for ordering in a timely manner. The policy for the service stated 'If it is necessary to order and/or collect medication for the customer, the details will be in the care plan. Ensure this is carried out in plenty of time before the medication runs out'. One person had been without one medication for five consecutive days and on an additional three occasions in the same month. There were potential side effects for missing this medication. Three people had also missed multiple doses of medication. No action had been taken by staff to report this or to ensure the person would not be adversely affected. They had recorded in the daily notes that all medication had been administered. Whilst people had not come to harm on these occasions there are potential risks where people do not receive their medication as required.

Where medication was not in a 'blister pack', there was no record kept of the stock available. This meant that checks could not be made should there be any concern that a medication had not been administered or was missing.

We saw that one person's medication administration record (MAR) indicated that they had been prescribed a product to thicken any fluids. However, it did not state how much product was required to achieve the required consistency. We checked their care plans to find no indication as to why this was required. Staff told us that this had been purchased by family at a time when the person was having difficulty swallowing but did not think it had been used. The registered manager stated that it must have been prescribed as staff do not administer without a GP prescription. However, the medication policy contradicted this as it indicted staff were' not authorised to administer an over the counter medicine unless its use has been checked with the GP as safe and appropriate with the customer's existing medication and medical condition, and it has been added to the care plan and MAR chart'.

The MAR had not been signed so no check could be made as to who had made the entry and on what grounds. We found this to be the case with other MARs. The registered manager informed us that staff completed the MARs as they were not pre-printed by the pharmacy. We found these were not signed by the person completing them or double checked by another member of staff to ensure accuracy which would be best practice. The policy indicated that 'Registered Managers will ensure that once the MAR chart is completed it is checked and a record made on Coldharbour that the MAR chart is correct in the customer record'. This had not been done.

Following the inspection, the registered manager informed us that arrangements had been made to re-evaluate staff competency in the management and administration of medication. Steps were also put in place to ensure the arrangements for the ordering of medicines was more robust and that practice was reviewed to reflect current best practice guidance.

Medications were administered via a feeding tube for one person as they were at risk of choking with oral food and fluid. There was a detailed individual plan was in place. Staff were aware of this and how to administer in line with the guidance. However, the care plans in place for medication support indicated 'I would like my carer to check my MAR sheet and to decant my medication and hand it to me to take with a glass of water, please watch me to ensure that I take them'. This contradictory information meant that there was a risk that medication may not be administered safely by staff who did not know the person well.

Where there was a risk of refusal, no risk assessment was in place to direct staff as to how to manage this. One care plan stated 'If I refuse please tell me how dangerous it is if I don't take them'. The detail surrounding the risk of refusal or the person's mental capacity to understand the risks was not included in any of the risk assessments. Staff told us that they would report any refusal to the office.

We found that risk assessments were not always detailed enough to ensure that support could be provided in a safe manner and placed people at potential risk.

Some people used equipment to facilitate their care and treatment such as a bath hoist. Each person's risk assessment for the use of this particular equipment was identical indicating there was no individual assessment of risk. There was no detailed handling plan to demonstrate that the equipment had been deemed as suitable for that person to use, how the number of staff required had been determined and what other risk factors might be in place. For example, one person who used the equipment was registered blind and another could be a 'Little confused'. A third person, we were told by staff, liked a bath very late at night often after they had "A little drink". No account had been taken as to how these factors this could impact on the task. This meant that there was a failure to assess the risks to the health and safety of people receiving care and treatment.

Staff informed us that they had recently been instructed that the lap-strap should always be used for safety whilst a person was using the bath hoist and if they refused they would not carry out the task. One person we spoke with told us that they did not like the strap, refused to use it and were happy take the risk. Their records indicated that on the 30 December 2017, 2 January 2018 and 6 January 2018 they had refused the safety strap yet the staff had supported contrary to guidance. The registered manager was not aware that this had taken place. There was no risk assessment in place to indicate the risks of that person using the equipment without the belt or the person's full ability to understand and accept those risks. This meant that there was a failure to carry out a risk assessment that balanced the needs and safety of people using the service with their rights and preferences.

The registered provider had a risk assessment for staff to complete to look at the risks presented by the environment in which they carried out personal care such as trailing wires, pets, smoking or chemicals used in cleaning. We found that these had not been completed in any of the records we reviewed.

Staff had an awareness of safeguarding adults and what this meant in practice for them. They were aware of how to report concerns and felt confident that issues would be addressed. The registered manager completed a monthly return to the local authority that outlined any minor risks occurring as a result of an isolated case of poor practice. However, we found that they had not reported all such concerns, such as those associated with missed medication. This meant that not all incidents were fully investigated to

minimise the risk of future harm.

These were a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014 because people were not prevented from the risks associated with unsafe care and treatment or avoidable harm.

The registered provider operated a safe and robust recruitment process. Pre-employment checks were conducted including obtaining full employment history, checks on identification, references from previous employers and Disclosure and Barring Service (DBS) checks. DBS checks help employers make safer recruitment decisions and help to prevent unsuitable people from working with vulnerable adults.

Staff were present in the building at all times and were given a plan of work for each day. Staff told us that they had enough time to complete all the visits and tasks required. Rotas were planned so that people had consistency of staff which meant staff got to know people well. We looked at a sample of rotas which confirmed this.

Staff understood their roles and responsibilities in relation to infection control and told us they had adequate supplies of PPE (personal protection equipment). Records also showed that spot checks had been undertaken to observe this area of staff's practice.

Incidents and accidents were documented and the registered provider required that each was investigated. Information from each incident was entered into an electronic record which then picked up themes and trends for individuals as well as the overall service. This meant that the provider had a good overview of those accidents and incidents that had been reported enabling them to put measures in place to prevent reoccurrence.

The building was maintained by Advantage, who is the housing provider. They were responsible for ensuring that it was safe. It was their responsibility to ensure and that suitable checks were carried out on the maintenance of equipment and utilities. They were also responsible for fire safety and evacuation procedures.

A business continuity plan was in place to ensure people would continue to receive care following an emergency. This described potential issues such as lack of staff and had solutions readily in place

Requires Improvement

Is the service effective?

Our findings

People told us that they were supported well by the staff and that staff respected their views. Comments included "I have confidence in the staff and their abilities" and "Staff respect my wishes and ask how I would like things to be done".

The incident that had occurred prior to this inspection and other information of concern received following the last inspection, led us to examine how the registered provider addressed issues where a persons' mental capacity to make decisions about their care could be brought into question. This particularly included people's mental capacity to make choices or decisions deemed to be unwise.

The Mental Capacity Act (MCA) 2005 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. We checked whether the service was working within the principles of the MCA.

The registered manager advised a number of people being supported were living with dementia and had varied levels of capacity to make decisions about their care. Staff told us that they offered people choices as to how their support was to be provided but that sometimes they had to make decisions for people; they said that this was where someone lacked capacity or where they could be putting themselves at risk.

MCA assessments and 'best interests' decisions were not carried out for people who may have lacked capacity to make certain decisions for themselves. This meant records did not consistently show which decisions people could make, and which decisions needed to be made on their behalf in their best interests. It is vital that staff record a best interests decision as there must be an objective record should a decision or decision-making process be later be challenged.

People have the right to make decisions that others might think are unwise and should not automatically be labelled as lacking the capacity to make a decision. The MCA aims to balance an individual's right to make decisions for themselves with their right to be protected from harm if they lack capacity to make decisions to protect themselves. However, staff had not undertaken an assessment of a person's mental capacity to make an unwise choice or their understanding of the risks associated with this.

We found, from looking at records, a lack of evidence to support restrictive practices that staff undertook. For example, we found examples where alcohol was being restricted by staff from a person or another where staff were discouraging a person from drinking: this was because staff had identified a risk of harm. There was no indication as to whether the person was able and had agreed to this restriction. The supporting care

plans indicated the persons could make a decision as to 'What to eat drink or clothes to wear'. Staff informed us that these decisions had been made by the social worker and that they were following instruction.

Where medication was being administered by staff, there was no agreed consent or assessment of a person's mental capacity to agree to this if being carried out in their best interest. There was a medication box in each apartment which was kept locked and the keys put on top of it out of reach or on occasions kept in the office. Staff told us that this was to prevent people from accessing medication and taking the wrong things at the wrong time. There was no assessment of each person's capacity in regards to this or evidence that they had consented to staff locking their medicines away from their use.

Staff were withholding medication if they had identified the person had been drinking alcohol. In one instance, there was evidence that a GP had been consulted and had advised staff to do this due to the contraindications. However, there was no mental capacity assessment or best interest decision in place to demonstrate the person's capacity to understand the risks on each occasion or the risks of not having the medication on their wellbeing.

Family members had sometimes been involved in support planning and agreements made about a person's care. We found that, on occasions, they had signed to 'consent' on behalf of the person. However, there was no evidence that they had the legal authority such as with a lasting power of attorney for health and welfare.

These are a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the registered provider failed to demonstrate that they were providing care and treatment with the consent of the relevant person.

Staff had training opportunities made available to them on a regular basis. Some training focused on key areas of practice such as safeguarding, moving and handling, mental capacity and first aid. This was repeated at regular intervals. However, the inspection had identified that staff were not always able to relate the 'theory to practice' such as understanding the Mental Capacity Act and how this related to care practice. There was also a lack of direct observations of staff by managers in regards to the use of equipment or the administration of medication to ensure staff's on-going competence.

Following the inspection, the registered manager informed us that additional training was to be undertaken in these key areas which would be followed up by staff competency checks.

Other training was delivered to ensure that staff had specific skills to enable them to provide the right support to an individual. For example; catheter care, wound care or supporting feeding through a tube (Percutaneous Endoscopic Gastrostomy (PEG) feeding). This training was delivered by a Nurse employed by the registered provider and each staff member had received a competency assessment on each task. This meant that staff had been provided with the background clinical knowledge to support them in their roles.

People were supported to maintain a good fluid and food intake. Staff assisted some people to prepare food and snacks within their own apartments. Others were assisted to have a meal in the Bistro which was open throughout the day. One person told us that they liked eating there as it made a meal time more sociable and it was good to get out of "the four walls".

Requires Improvement

Is the service well-led?

Our findings

People were happy with the management of the service and confirmed that their opinion was sought on a regular basis about the service provided by care staff and the housing provider.

A registered manager was in post and had been registered with the Care Quality Commission (CQC) since September 2015.

The registered provider had policies and procedures in place to support staff in their day to day work. These, however, were not readily available to staff and were not up to date.

A number of policies had been reviewed yet account was not taken of the latest guidance, best practice or CQC regulations under the Health and Social Care Act 2008. For example: the complaints policy dated 2 February 2016 stated "This policy meets the requirements of CQC's Essential Standards of Quality and Safety Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2009; Outcome 16. There had been an update of the Health and Social Care Act 2008 (Regulated Activities) Regulations in 2014 and this was incorrect.

The service did not measure and review the delivery of care, treatment and support against current guidance as polices were out of date and did not reflect current CQC regulations or best practice guidance. The medication policy was last reviewed in February 2016 but it had not been further updated to ensure that it met with national guidance (Managing medicines for adults receiving social care in the community) published by National Institute for Health and Care Excellence (NICE) issued in March 2017. We found that staff practices did not reflect this guidance. The infection control policy was reviewed in April 2017 yet did not refer to the Health and Social Care Act 2008 Code of Practice on the prevention and control of infections and related guidance published in March 2014. This demonstrated that the registered provider had failed to implement nationally recognised guidance and so there was a risk that staff were not aware of current best practice or legal requirements.

We found that the information from the recent incidents and investigations had not been used to inform and drive quality as we identified a number of actions that were still required.

We found that the issues identified during our inspection were not recognised or always picked up within the quality monitoring systems employed. For example; the lack of individualised risk assessments, non-compliance with the MCA , inaccurate documentation or concerns around medication which we found on the inspection. This meant that the quality assurance, information and governance systems were not effective in supporting and evaluating learning.

In addition, risk assessments did not provide enough information to enable staff to provide safe care but this had not been identified by the management audits undertaken. We also found that some care plans and risk assessments had been dated incorrectly. This meant that they were not an accurate record of the care and support at a given time. It also meant that we could not be assured when any documents had in fact been

completed.

Audits were undertaken of medication administration records (MAR's) and these highlighted poor practice such as missing signatures. Action was then taken to monitor the practice of staff competency. However, these did not highlight or address those situations where medication had been missed or not available for staff to administer. As a result, these had not been investigated to ensure that no harm had been caused or steps taken to prevent this from occurring again.

These were a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the registered provider failed to ensure that its governance systems were robust. They also failed to ensure that there was an accurate, complete and detailed record in respect of persons using the service.

Immediately following the inspection, the registered manager and registered provider forwarded an action plan that looked to address the issues and concerns in regards to robust auditing as well as the other concerns raised on inspection.

Meetings were held with staff and people who used the service to discuss any concerns that they had and to update on any matters of relevance. This meant that people and staff were given the opportunity to share their thoughts and observations about the service.

People and staff said that the registered manager was often on the premises and if she was at another site they knew where to contact her. However, the point of call for most concerns appeared to the be senior. Staff said that she was most supportive and always on call even on days that she was not rostered to work. Staff said that the team were cooperative, supportive and worked well together. They would cover sickness and other absences with a shared responsibility.

There was a use of information technology systems used to monitor and improve the quality of care. People had access to a call system whereby they could call staff in an emergency and this they said make them " Feel safe". The service had a vision to work in a person-centred way. Staff told us that they did their best to involve people in things that went on within the scheme. They had understanding of promoting dignity and independence.

The registered manager was aware of the requirements of their registration and what they needed to do to comply with the regulations.

There was a display of the previous CQC rating in the building and also on the registered provider's website.

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
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The registered provider had failed to demonstrate that care and treatment was delivered with appropriate consent or that staff were acting in a persons best interest.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered provider did not ensure that people received safe care and treatment.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered provider did not ensure that there was robust oversight of the quality and safety of the service. Records were not complete or accurate.