

Random inspection report

Care homes for older people

Name:	Haslingden Hall and Lodge
Address:	Lancaster Avenue Haslingden Lancashire BB4 4HP

The quality rating for this care home is:	two star good service
The rating was made on:	

A quality rating is our assessment of how well a care home, agency or scheme is meeting the needs of the people who use it. We give a quality rating following a full review of the service. We call this review a 'key' inspection.

This is a report of a **random inspection** of this care home. A random inspection is a short, focussed review of the service. Details of how to get other inspection reports for this care home, including the last key inspection report, can be found on the last page of this report.

Lead inspector:	Date:							
Susan Hargreaves	2	3	0	3	2	0	1	0

Information about the care home

Name of care home:	Haslingden Hall and Lodge
Address:	Lancaster Avenue Haslingden Lancashire BB4 4HP
Telephone number:	08456032544
Fax number:	01706214413
Email address:	haslingdenlodge@orchardcarehomes.com
Provider web address:	www.orchardcarehomes.com

Name of registered provider(s):	Orchard Care Homes.Com Limited
Type of registration:	care home
Number of places registered:	76

Conditions of registration:		
Category(ies) :	Number of places (if applicable):	
	Under 65	Over 65
dementia	36	0
old age, not falling within any other category	0	40

Conditions of registration:								
The registered person may provide the following categories of service only: Care home only - Code PC To people of either gender whose primary care needs on admission to the home are within the following categories: Old age, not falling within any other category - Code OP (maximum number of places: 40) Dementia - Code DE (Maximum number of places 36) The maximum number of people who can be accommodated is 76.								
Date of last inspection								
Brief description of the care home								
Haslingen Hall Lodge home is a purpose built 76-bedded property in a residential area of Haslingden that was registered in 2006. The home is divided into two units a 40 bedded unit for older people who need personal care and a 36 bedded unit for older people who suffer from dementia. There are local shops nearby and there is access to Haslingden town centre, which is about one and a half miles away. The registered								

Brief description of the care home

persons are Orchard Care Homes Limited. The company have a number of other homes throughout the country, which are registered with the Commission for Social Care Inspection. All bedrooms are single with an en-suite toilet with shower. There is a lounge and dining area with a kitchen on each floor. There is access to a garden from the conservatory on the ground floor and a first floor terrace can be accessed from french doors on the landing. Information about the home is given to prospective residents and a copy also provided in their bedroom when they come in to the home to live. The fees ranged from £386 to £585 per week. The fee did not include hairdressing or private chiropody treatment.

What we found:

The quality rating for this service is 2 stars. This means that the people who use this service experience good outcomes.

The reason for this random inspection was to look at the standard of care following concerns raised by the relatives of several people who have used or are using the service.

We looked at the care plans of six people using the service. These plans identified some health and personal care needs and provided directions for staff to follow to ensure their individual needs were met. Care plans also included information about people's likes and dislikes and their preferred daily routine. This information helped to ensure that people were being cared for in the way they want. However, there was no designated section seen in any of the care plans relating to healthcare needs. This included how to manage and monitor conditions such as diabetes and acute problems such as infections. Having detailed information and clear directions for staff to follow ensures that healthcare needs are managed correctly.

Behaviour charts had been completed for one person but these had not been evaluated and a care plan about how best to manage and respond to the person's aggressive behaviour had not been developed.

Although care plans were reviewed monthly any changes to the care needs of the person were usually recorded in the evaluation section of the records instead of the care plan. Updating care plans when the needs of the person change ensures members of staff know exactly what they need to do to in order meet the individual needs of each person.

Appropriate risk assessments including ones for falls, nutrition and the development of pressure sores were in place. Guidance for staff to follow about how to manage identified risks was also included in the care plans.

A written report about the care given to each person using the service was written during each shift. This ensured that all staff had up to date information about the condition of each person in order to ensure continuity of their care.

There were records of the involvement of GP's and other healthcare professionals including the chiropodist and district nurse in the care of people who use the service.

Medication was stored correctly and administered by members of staff who had received training in the management of medication. We looked at the records for the management of medication. These included a record of medication received into the home and a record of unused medication returned to the pharmacy.

Hand written instructions on the medication administration records were not always signed or witnessed by another member of staff to indicate that the instructions had been copied correctly. We saw instructions which had been copied incorrectly because they did not include that the medication had to be taken one hour before food. This meant the person was not given their medication one hour before lunch on the day of this visit. Giving medication at the wrong time in relation to food can seriously affect the health and

wellbeing of people using the service.

We looked at how staff recorded the application of creams and ointments. There were no clear directions for staff to follow about how to use these and one of the records indicated that the person had not had their cream applied on several occasions. The reason why this medication had been omitted was not recorded. The senior member of staff on duty explained there was none on the premises and they had probably run out. Running out of prescribed medication can seriously affect the health and wellbeing of people using the service. Cream prescribed for one person was found in the room of a different person. This increases the risk of error and misuse. The manager was advised to ensure that all creams and ointments were stored securely to prevent their misuse and their inappropriate use by people suffering from dementia.

We checked how controlled drugs were handled, these are medicines that can be misused. A special register was used for record keeping and was seen to have been completed correctly.

We looked at the records of how medication was checked by the manager. These records indicated that all aspects of the management of medication was audited every month including staff competence. These checks help to ensure that medication is managed safely and any problems are dealt with promptly.

We spent most of the morning in one of the lounges in the Haslingden Lodge dementia unit. During this time we observed that there was very limited conversation between the staff and people using the service. Any interaction tended to focus on people's functional needs for example going to the toilet or having a drink. The television was on for part of the time but the chairs were arranged in a way that prevented some people from seeing the screen. Later on people were asked if they would like to listen to some music instead of watching television and the radio was put on.

A healthcare professional came to take a specimen of blood from one person. This person wasn't asked and staff did not offer to take the person to their own room so the procedure was carried out in the lounge. To ensure privacy and dignity is promoted for people using the service healthcare procedures must take place in private.

During the morning a gentleman came to do exercises with people using the service. This activity was done individually with several people and involved them doing exercises for a few minutes each. The people involved appeared to enjoy the activity and the attention they received.

There were activity records kept within each person's care plan. Although these had not been completed for several weeks the activities listed included, 'enjoyed a cup of tea', 'enjoyed ice cream' and 'watching the fish'. It was written in the care plan for one person that he liked cards and walking in the grounds but neither of these activities were reflected in his activity records. The deputy manager told us that a reminiscence activity organised by a local museum had been arranged for the afternoon on the day of this visit and people from all areas of the home were invited to attend. However, a visiting relative told us that they had asked for activities to take place in the lounge on the dementia unit as well as in Haslingden Hall. Providing a range of suitable activities for people suffering from dementia helps to promote their health and wellbeing.

The meal served at lunchtime looked appetising and although people had been asked the day before for their choice of meal, they were all asked again what choice they wished to make when the meal arrived. People using the service were given sensitive and appropriate assistance to eat their meals.

We looked at the records of complaints made in the last six months. These included detailed information about each complaint, the investigation and the action taken to resolve the problem. One visitor told us that she would discuss any problems with the manager and was confident that he would deal with them. This visitor also told us that she had made a formal complaint over a year ago and the manager had taken appropriate action to deal with the issues raised.

Some areas of the home looked to be in need of cleaning and discussion with a cleaner and the manager confirmed that the ground floor and first floor were each cleaned on alternate days. We also noticed a strong smell of urine in some of the corridors and bedrooms. One visitor told us that the odour was worse some days than others. An unpleasant odour does not promote the health and wellbeing of people using the service.

During this visit there were times when a member of staff was not present in the lounge to supervise people suffering from dementia in order to ensure their safety and wellbeing. We discussed this issue and staffing levels generally with the manager. He explained that three members of staff were on duty on that floor between 8am and 8pm. One member of staff stayed in the lounge area to interact with service users but during staff breaks if someone needed the assistance of two carers then it wasn't possible to have a member of staff in the lounge. This should be reviewed to ensure people using the service are not put at risk because of a lack of staff supervision. One visitor told us that on the whole the care was good and they did not have to wait long if her relative needed staff to help them.

What the care home does well:

To comply with a recommendation made at the last key inspection the manager has kept written records of all complaints, the investigation and any action taken.

What they could do better:

Care plans must identify all the health and personal care needs of each person using the service and provide clear directions for staff to follow in order to ensure their individual needs are met. When care plans are reviewed any changes to the care required should be written in the person's individual care plan. This will ensure members of staff have up to date information about the care needs of each person using the service. Repeat prescriptions must be ordered in time to prevent people from running out of their prescribed medication.

To ensure people receive the treatment they need medication must be given as prescribed by the doctor and at the right time in relation to food. To prevent mistakes being made hand written instructions on the medication administration records should be signed and witnessed to check these have been copied correctly.

A system for the safe handling and recording of prescribed creams and ointments must be put in place. This includes storing them securely, providing clear guidance for staff to

follow about their use and if they are omitted the reason why must be recorded.

To promote privacy and dignity for people using the service healthcare procedures must be carried out in private.

To promote the wellbeing of people suffering from dementia it is important for members of staff to engage them in conversation and offer meaningful activities.

To ensure people using the service live in a pleasant and homely environment action must be taken to deal with the unpleasant odour in a number of bedrooms and corridors.

The manager should review staffing arrangements in order to ensure that people suffering from dementia are properly supervised when members of staff have their break.

If you want to know what action the person responsible for this care home is taking following this report, you can contact them using the details set out on page 2.

Are there any outstanding requirements from the last inspection?

Yes

No

Outstanding statutory requirements

These are requirements that were set at the previous inspection, but have still not been met. They say what the registered person had to do to meet the Care Standards Act 2000, Regulations 2001 and the National Minimum Standards.

No.	Standard	Regulation	Requirement	Timescale for action

Requirements and recommendations from this inspection:

Immediate requirements:

These are immediate requirements that were set on the day we visited this care home. The registered person had to meet these within 48 hours.

No.	Standard	Regulation	Requirement	Timescale for action

Statutory requirements

These requirements set out what the registered person must do to meet the Care Standards Act 2000, Regulations 2001 and the National Minimum Standards. The registered person(s) must do this within the timescales we have set.

No.	Standard	Regulation	Requirement	Timescale for action
1	7	15	Care plans must accurately identify and address all the care needs of each person using the service. This will ensure that all care workers know what they need to do in order to meet the needs of each person using the service.	14/05/2010
2	9	13	Arrangements must be made for the safe handling and recording of prescribed creams and ointments. This will ensure they are used safely and as prescribed by the doctor.	30/04/2010
3	9	13	A system must be put on place for the prompt ordering of repeat prescriptions. This will ensure people do not run out of their prescribed medication.	30/04/2010
4	9	13	Medicines must be given to people at the right time in relation to food.	30/04/2010

Statutory requirements

These requirements set out what the registered person must do to meet the Care Standards Act 2000, Regulations 2001 and the National Minimum Standards. The registered person(s) must do this within the timescales we have set.

No.	Standard	Regulation	Requirement	Timescale for action
			Receiving medicines at the wrong time can affect the health and wellbeing of people using the service.	
5	10	12	Healthcare procedures must be carried out in private. This will ensure that privacy and dignity is promoted for all people using the service.	30/04/2010
6	26	16	All areas of the home must be free from offensive odours. This will provide a more homely environment and help to promote the wellbeing of people using the service.	31/05/2010

Recommendations

These recommendations are taken from the best practice described in the National Minimum Standards and the registered person(s) should consider them as a way of improving their service.

No	Refer to Standard	Good Practice Recommendations
1	7	When care plans are evaluated any changes to the care required should be written in that person's individual care plan. This will ensure members of staff have up to date information about the care needs of each person using the service.
2	9	Hand written instructions on the medication administration records should be signed and witnessed. This ensures that instructions have been copied correctly.
3	12	To promote the wellbeing of people suffering from dementia members of staff should be encouraged to engage them in conversation and offer meaningful activities.

Recommendations

These recommendations are taken from the best practice described in the National Minimum Standards and the registered person(s) should consider them as a way of improving their service.

No	Refer to Standard	Good Practice Recommendations
4	27	Staffing arrangements should be reviewed in order to ensure that people suffering from dementia are properly supervised when members of staff have their break.

Reader Information

Document Purpose:	Inspection Report
Author:	Care Quality Commission
Audience:	General Public
Further copies from:	0870 240 7535 (telephone order line)

Our duty to regulate social care services is set out in the Care Standards Act 2000. Copies of the National Minimum Standards –Care Homes for Older People can be found at www.dh.gov.uk or got from The Stationery Office (TSO) PO Box 29, St Crispins, Duke Street, Norwich, NR3 1GN. Tel: 0870 600 5522. Online ordering from the Stationery Office is also available: www.tso.co.uk/bookshop

Helpline:

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Email: enquiries@cqc.org.uk

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