Adiemus Care Limited

Heathmount

Inspection report

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Ratings

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

Overall summary

Our visits to Heathmount were unannounced and took place on 17 and 24 October 2014.

Heathmount is a care home with nursing. It is registered to provide care, treatment and support for up to 31 people. At the time of our visit 20 people were living there. People who lived at Heathmount had some physical frailty; some were also living with dementia which impacted upon the quality of their lives.

Heathmount is on the same site as two other services provided by Adiemus Care Ltd These are; Silver Birches (a care home without nursing) and Copper Beeches (a care home with nursing). All are separately registered with CQC. The overall site has been renamed "The Beeches Care Centre". The provider has decided to keep the three homes as separate entities which means they will continue to be separately registered with CQC and have their own inspections.

There was a general manager at Heathmount who had yet to apply to be registered with CQC. The provider said they will apply for the registration of one registered manager across the site. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are

Summary of findings

'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.

Our previous inspection in June 2013 concluded staff needed to improve their record keeping. This related particularly to how accurately staff recorded the needs of people who were at high risk of becoming unwell, for example if they needed to have their fluid intake closely monitored. In August 2013 the registered manager in post at the time submitted an action plan which explained how they had addressed the concerns raised. During this visit we found improvements had been made and monitoring records of people's food and fluid intake were accurate and fit for purpose.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see the action we told the provider they must take at the back of the full version of this report. People's physical needs were being met however, communication from staff meant at times their emotional needs were not understood. There needed to be more guidance for staff about what to do if a person became distressed so they could ensure a consistent approach. The number of activities was limited. There was good information in people's plans of care about what people liked and what they were interested in there was little evidence this was being used to provide activities that reflected their choices, interests and needs.

Staff did not have a sufficient understanding of the Mental Capacity Act 2005 and how to apply it. This meant there was a risk they were making decisions on people's behalf without properly establishing people could not do this for themselves.

There was a lack of clarity in management arrangements and people did not always know who was in charge. This had an impact throughout the home as, for example, people did not know who to discuss their worries or concerns with. Despite audits identifying issues, the manager and the registered provider had not taken action to ensure they were addressed in a timely way.

Individual risks to people's health and safety were identified and staff liaised with appropriate health and social care professionals when there was a need to do so to keep people as safe as possible. There were sufficient numbers of care and nursing staff employed and managers regularly monitored staffing levels to ensure these remained appropriate. Staff were safely recruited and had access to a range of training which helped them understand people's needs. People had the support they needed to maintain a balanced diet which took into account their dietary needs and preferences.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Medicines were safely managed.

There were sufficient numbers of appropriately recruited staff to keep people safe.

Risks to people's health and wellbeing were monitored and action was taken where necessary to keep people as healthy as possible.

Staff knew how to recognise and report abuse.

Is the service effective?

Requires Improvement

The service was not effective.

Improvements were needed to ensure more effective communication between staff and people who lived at Heathmount.

People's capacity to consent to their care and treatment needed to be more clearly understood by staff and demonstrated.

People had access to appropriate healthcare.

People received a balanced diet and those most at risk of poor nutrition were closely monitored.

Staff received a range of training to help them to meet people's needs.

Is the service caring?

Requires Improvement

The service was not always caring.

Although there were some good interactions we saw occasions where staff were not respectful

People's privacy was respected

There were some opportunities for people to be involved in the daily routines of the home.

Is the service responsive?

Requires Improvement

The service was not responsive.

Although people's plans of care reflected their interests and wishes, these were not reflected in how they experienced their daily lives.

The complaints process needed to be more accessible so people's worries and concerns were known about and acted upon by staff.

Summary of findings

Is the service well-led?

Inadequate 

The service was not well led.

There was no visible manager and although the service had clear vision and values, this philosophy of care was not observed in practice.

Quality assurance systems were evident but they did not always identify shortfalls in the service and and ensure improvements were put right within a reasonable time.

Heathmount

Detailed findings

Background to this inspection

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

This inspection took place on 17 and 24 October 2014 and was unannounced.

The inspection team consisted of an inspector and expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert by experience who assisted with this inspection had experience of dementia care.

Before our inspection we reviewed information we held about the service. This included any statutory notifications that had been sent to us. A statutory notification is information about important events which the service is required to tell us about by law. Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We spoke with 11 people who lived at the home, two relatives, nine staff and with the manager. We observed how care and support was provided to people. We looked at eight people's support plans, staff recruitment and training records, staff rotas, and records relating to how staff monitored the quality of the service.

Following our visit we spoke with one social care professional.

Good

Is the service safe?

Our findings

People said they felt safe at Heathmount and a visiting relative agreed, saying their mother was safe and content.

There were policies and procedures about how to keep people safe from abuse. These contained guidance about who to report any concern to and explained staff rights and responsibilities under whistleblowing arrangements. These policies were discussed at staff meetings so staff were fully aware of them. Staff we spoke with said they felt confident to raise any concerns if they felt people were not safe and were confident any concerns raised with senior staff would be appropriately addressed.

Staff helped to ensure people were as healthy as possible. Staff regularly assessed whether people's health was deteriorating for example, where they were at risk of becoming malnourished or not drinking enough or where they were are risk of their skin breaking down. Action had been taken where necessary. For example, people's fluid intake was monitored to reduce the risk of them becoming dehydrated and pressure relieving equipment had been provided to keep people safe and comfortable. People's weights were monitored and action was taken by consulting and following advice from a GP if people had lost weight. Staff kept a record of accidents including when people had fallen. When there was no obvious injury, staff monitored people more closely than usual for 24 hours to ensure their wellbeing. Environmental risks were also considered, such as what staff should do in the event of a fire. Staff said personal emergency evacuation plans (PEEPS) had been updated recently to ensure they remained accurate and appropriate to keep people as safe as possible.

The manager said staffing levels were assessed to take account of people's level of dependency and this was reviewed regularly to ensure there were enough staff deployed at Heathmount to keep people safe. Rotas showed there was always a registered nurse on duty. Nursing and care staff said they had enough time to provide care and had a good understanding of people's needs. Two vacancies for nurses were covered by regular bank nurses who knew people at Heathmount. Nurses said managers brought in more staff to assist at busy times such as when they were helping somebody who had just moved to the service to settle in. We observed staff attending to people who needed support to eat and drink when they needed help to do this.

There were safe recruitment processes in place. Staff said there had been appropriate checks completed before they started to work at Heathmount. This was supported when we checked recruitment records for staff who had been employed recently. Criminal record checks had been made and references had been taken from previous employers to help ensure staff were suitable for their role.

People were happy about the way in which staff helped them with their medicines.

Procedures relating to how medicines were supplied, stored and disposed of were appropriate.

No one at Heathmount managed their own medicines, although staff said people were always asked if they wanted to do this. Staff checked people's prescriptions against the medicines delivered from the pharmacy to ensure they corresponded. Medicines were stored securely and at the correct temperature. We observed part of a medicine round and saw the nurse explained what each medicine was for and ensured each person had a drink to take with their medication. Nurses also asked people if they were in any pain and provided pain relief if required.

Requires Improvement

Is the service effective?

Our findings

People liked the staff but some felt there was a bit of a language barrier at times with a few staff whose first language was not English. This meant some staff could not always understand what people were asking of them. One person said some staff were a bit rough when they helped to move them by hoisting. We observed staff at times helped people to move when they were resistant to this. Staff were not rough but there was not much communication between them and the people concerned to try to allay their anxieties. Although we did not see any evidence this was done in a way which was not safe or uncaring the fact some people could become quickly distressed was noted in their care records. There was no written guidance for staff about the most effective way to reassure them. There were some people who needed 'as required' (PRN) medicines, for example, one person needed medicine at times when they experienced periods of agitation. Staff who administered medicines were able to describe what they would do to try to calm the person before they decided this medicine was necessary; however there was no written guidance about this. This increased the risk of staff not acting consistently and effectively to meet people's needs . The need to improve 'as required' care plans had already been identified during a recent audit and staff were about to start work on this at the time of our inspection.

The verbal feedback from people, our own observations, and the lack of written guidance for people who could become distressed meant there was a breach of Regulation 9 of the of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This was because staff were not meeting people's individual needs effectively.

Systems to gain and review consent from people were not consistent. People's mental capacity had been considered during people's initial assessment of their needs. Some people had capacity, and staff consulted with them about how they wanted their care and treatment to be managed, for example some people had a DNAR form (Do Not Attempt Resuscitation). The DNAR forms had been discussed and signed by the person in consultation with a doctor. The completed forms had been placed in the front of their care records so staff would know what they should do in a medical emergency.

Other people were assessed as having variable mental capacity. Where people's capacity was in doubt it was not always clear staff had consistently followed the principles of the Mental Capacity Act 2005. For example, one key principal is that a person is not to be treated as unable to make a decision unless all practicable steps to help them to do so have been taken without success. Staff could not explain how this was done and there was a generic consent form on most people's records which said 'I give consent to the following: – care plans written in best interest, medication management, photographs, routine blood tests and influenza vaccines'. These had sometimes been signed by the person but other times they had been signed by next of kin. These decisions were not personalised and we saw staff had at times made decisions on people's behalf without demonstrating they had determined the person lacked capacity to make decisions for themselves. An example of this was the rationing one person's cigarettes. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. One person was currently subject to a (DoLS) restriction in their own best interests following the correct applications having been made and agreed. Senior staff understood when an application should be made, and were in the process of making applications where necessary.

People had their needs assessed before they moved to the service to ensure it would be appropriate for them. Plans for care were devised from this initial assessment. These were updated regularly and so gave a clear picture of what people needed in terms of their care, support and treatment. People's health care needs were identified as part of the care planning process and they were effectively monitored. A local GP and a practice nurse attended regularly and also attended in an emergency. People appreciated that they were able to get to know the visiting health professionals and valued the consistency in these relationships. People had regular health checks when needed such as eye tests and chiropody appointments. People had input from specialist health care professionals when they needed it, for example the tissue viability nurse assisted when there was a particular problem in maintaining the integrity of people's skin.

Requires Improvement

Is the service effective?

People were supported to have sufficient to eat and drink and to maintain a balanced diet. Staff provided the cook with a list of people who needed special diets and we saw these were accurately recorded, for example the cook was aware of people who needed a diabetic diet. Staff provided appropriate assistance to people when they needed help to eat their meals. Records showed people had been offered drinks and food regularly throughout the day and where necessary amounts of food and fluid taken had been recorded. Staff were aware of the amount each person had eaten and drunk each day and demonstrated a good understanding of people's nutritional needs.

Staff said they were provided with good training and the training records showed staff had received an induction when they started to work at Heathmount. This helped them to understand the basic needs of people who lived at the home and included general aspects of care such as the importance of maintaining people's confidentiality. Staff said they had recently updated training in key areas such as infection control and dementia awareness.

Staff received supervision from senior staff which helped to ensure they had access to support, training and procedures they required for professional growth and development.

Requires Improvement

Is the service caring?

Our findings

There was a lack of consistency in the caring approach of staff. One person said staff were generally kind but said "some staff do not enjoy what they do". Another person said staff were "ok."

Social interaction was limited and there were also some missed opportunities to relate to people, to make sure they felt they mattered and they were being listened to. One person repeatedly asked the same question throughout both days of our visits. Staff largely ignored them. This gave the impression the person was invisible and their requests did not warrant a reply. We observed staff responded after about the seventh or eighth time the question was asked. Although staff answered the question they did not engage or talk to the person about other things. When we asked this person what they were interested in they became much more animated and talked with enthusiasm and interest. The change in their demeanour was immediate.

Another person was being pushed in a wheelchair towards the dining room when the staff member helping them was called away to assist another person. The staff member did not explain why they had stopped pushing them. As a result the person was left in their wheelchair in the middle of the room. Staff came back fairly quickly but they did not say anything by way of an explanation and started to push the person again into the dining room.

Another person asked what the powder was in their glass, (it was a nutritional supplement) and staff did not answer but poured water in the glass and stirred it for them. The person was left without an explanation. The approach of some staff meant there was a breach of Regulation 17(the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 as staff had failed to demonstrate they were treating people with consideration and respect.

We also saw some people were treated with respect and compassion. For example a domestic staff observed a person did not look comfortable in bed and immediately searched out a member of care staff so they could check on them to ensure they were as comfortable as possible. This person's needs were quickly responded to. There was good information in people's care notes about the things they liked and who was important to them. Some staff had a very good understanding of this. This helped them to have meaningful conversations with people.

Staff were discrete in providing personal care; a label was hung on the outside of their door whenever personal care was being delivered so no potentially embarrassing interruptions occurred. The dining room was well laid out and tables were set in an attractive way. This helped to improve the quality of life of people's daily life.

There were some opportunities for people who lived at Heathmount to be actively involved in making decisions about life at the home. There were regular resident meetings and items on the agenda included things of interest to people such as how the laundry worked and possible social outings. People also took part in food committee meetings if they wanted to do this. Comments about the food were relayed to the chef and the minutes of a recent food committee meeting had noted people's appreciation the food had improved, because staff had acted upon the feedback received.

Requires Improvement

Is the service responsive?

Our findings

People said they sometimes had to wait a while for staff to respond when they pressed their call bells for assistance, but said any delay was not significant. We observed call bells were in easy reach and found staff answered them in good time when people requested help. People said they had not needed to make any complaints about the service. One person said they were "well looked after" and had "no complaints whatsoever". But one said "well, it might not be easy, (to complain) as sometimes they don't understand me." Another person said they were not sure who they should complain to as they never saw the manager. Care staff said they mostly had enough time to look after people but said there could sometimes be additional pressure at mealtimes if there were not sufficient catering staff on duty. Although this did not happen often, at these times, there could be a delay in people being served and helped with their meals

We asked the manager whether people had made any complaints. They were initially unsure, saying some people may have made verbal complaints but then said they thought no one had made any complaints in the four months they had been in post. There was no record kept of any complaints during this time. Whilst people had said they had no complaints to make they had some worries, for example, the person who told us they felt staff were a bit rough with them when they helped them to move and the person who told us not all staff understood them because of language difficulties. These complaints had not been dealt with in line with the services complaints procedure . This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) as there was not an effective system in place for identifying, receiving and handling complaints.

People were not sufficiently supported to follow their interests and take part in social activities. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 as the delivery of care did not meet people's individual social needs.

One person who used to participate regularly in activities said there was not much to go to in the lounge area for them and so they stayed in their bedroom. Whilst we understood there had been significant events in this person's life which meant they may have wanted to be less involved in communal life we did not see evidence staff had spent time talking with this person about what they may like to do instead, staff did this again during our visit.

There was an activity co coordinator employed at the service who had recently reduced their hours to two days a week. On one of the days of our visit they were present but they were updating people's records and so were not providing activities. We spoke with them and they demonstrated a clear interest in the people who lived at Heathmount and in creating appropriate activities for them.

The activity co coordinator had a scheme running called a 'virtual world voyage', where people talked about where they would like to go, and every Thursday appropriate national foods were served. Some people had travelled when they were younger so they could relate to this. However, it was not clear what other activities were provided to correspond to people's interests.

A large notice board was on display and this advertised daily activities. However the activities advertised did not happen during our visits. On both of these days no activities were provided at all

and people spent their time either in their bedroom where they were occupied with TV's, radios or books, or they were in the lounge area where a TV was on. Few people seemed to be interested in whatever television programme was on screen in the communal lounge. We did not see staff spending any time sitting and talking with people and there was not much in the way of casual social interaction. One person told us they wrote poetry and they recited poems to us. Their mood improved considerably whilst they were doing this. We did not see any evidence staff had followed up on this person's interest.

Records of social activities showed people were given one to one attention but there were a number of occasions when this one to one attention (provided by the activity coordinator) included accompanying people for hospital or other medical appointments. We discussed this with the manager as we felt this detracted from the time the activity coordinator had in fulfilling their main role.

People's care records contained information about their care and treatment needs and these were updated where necessary. There was information about people's likes, dislikes and interests and people's records gave us a good

Requires Improvement

Is the service responsive?

idea of what was important to them. We saw evidence some staff were aware of people's preferences, for example, staff ensured one person who liked to listen to classical music had this playing in their bedroom.

A comments book was kept in the dining room which related to food and this was well used with positive and negative comments and requests were made for certain foods. This was completed often with the assistance of the activity coordinator.

Inadequate

Is the service well-led?

Our findings

The home had a number of systems in place to monitor the quality of care treatment and support it provided. Although some improvements had been made as a result of quality assurance checks others had not been resolved in a timely way. For example, in May 2014 it had been identified that there was a problem with damp in two of the bedrooms. We looked at the bedrooms during our visit. Whilst the wall of one appeared to have been treated, the wall of the other one had coloured mould on one of the walls and this was on the same side as the person's bed. It was therefore evident this had not been attended to. The manager said they were not aware of this and this was evidence they were not managing effectively. The lack of action taken to remedy this situation indicated the service was not following its philosophy of treating people with dignity and respect and not regualry assessing and monitoring the quality of services provided. Some people did not know who the manager was. One person said for example "you never see anyone in charge, here – you just see the carers." This reinforced our judgement that the manager was not sufficiently visible and there was a lack of clarity in management arrangements.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 as the quality monitoring system was not effective.

The provider had not demonstrated robust oversight of the quality of the care people received.There was a manager in post although they had yet to apply for registration with CQC. The manager of Heathmount was also responsible for the two other services on the same site. The manager did not demonstrate they understood the needs of people who lived at Heathmount for example they always referred us to nursing staff when we asked general questions about people who lived at Heathmount.

The manager was supported by a clinical lead nurse who demonstrated a much better understanding of some, but not all, of the needs of people who lived at Heathmount.

The clinical lead nurse was also responsible for the other two services and at the time of our visit they were still the registered manager for Copper Beeches. There was a deputy manager who was based full time at Heathmount. They demonstrated a good understanding of the needs of all of the people at the home. The manager said the deputy manager was in day to day charge of the home although people who lived at the home did not seem to know this.

The service has a website and this says 'Our philosophy is simple; we want everyone to enjoy life to the full. We never forget that all our residents are individuals and we treat them with dignity, privacy and respect while offering freedom of choice and as much independence as possible'.

They go on to say: 'Residents have freedom to choose what to do and when. There is plenty going on and our activities coordinator puts together a full programme which is adapted to suit the needs and wishes of our residents'.

These are clearly defined vision and values, but the service was not following them. Whilst people were mostly happy with the care, treatment and support they received. We did not see much in the way of activities and whilst staff were generally kind in their interactions they tended to be task focused and they missed a lot of opportunities to chat with people. This had, at times compromised the values of treating people as individuals, with dignity and respect and offering them freedom of choice and the range of activities that were promised.

Most staff said they were happy in their role but some said morale could be better. Some staff said they did not always feel listened to. The manager held regular staff meetings, although these were held over the three locations. The most recent meeting had been attended by eight staff overall and so the number of staff who attended from Heathmount was minimal.

There were meetings for people and their relatives. The most recent meeting was held in August 2014 and the minutes of this meeting were accessible in the hallway for people to read if they wished.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers The registered person must protect service users against the risk of inappropriate or unsafe care by means of an effective quality monitoring system

Regulated activity	Regulation
	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment The registered person must have suitable arrangements in place for obtaining and acting in accordance with the consent of service users in relation to the care provided for them.

Regulated activity	Regulation
	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services The registered person must make suitable arrangements to ensure the dignity of service users

Regulated activity	Regulation
	Regulation 19 HSCA 2008 (Regulated Activities) Regulations 2010 Complaints The registered person must have an effective system in place for identifying, receiving and handling complaints and comments made by service users.

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services The registered person must take proper steps to ensure each service user is protected against the risks of receiving care that is inappropriate by planning and delivering care which meets service user's individual needs and ensures their welfare and safety.