Four Seasons Homes No 4 Limited

Heron House Care Home

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?	Good
Is the service responsive?	Good
Is the service well-led?	Requires Improvement

Overall summary

Heron House Care Home is registered to provide accommodation, support and care, including nursing care, for up to 92 people, some of whom have mental health needs. At the time of our visit 72 people were using the service. The home is arranged on one level and divided into four named units; Heron Court, Wendreda, Eastwood and Nene.

This unannounced inspection was undertaken on 13 January 2015. At our last inspection on 23 September 2014 we found breaches of regulations relating to care and welfare, management of medicines, supporting staff and assessing and monitoring the service provision.

Following that inspection the provider sent us an action plan to tell us what improvements they were going to make by no later than 09 December 2014. During this inspection we looked to see if these improvements had been made and also if the provider was meeting the other regulations. Some improvements had been made and some of the breaches of regulations identified at the previous inspection were now being met.

The home did not have a registered manager in post, because they left their post in December 2014, although their name remains on our register as we have not yet received an application to cancel their registration. A

Summary of findings

registered manager is a person who has registered with the Care Quality Commission (CQC) 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 and associated Regulations about how the service is run.

The CQC monitors the operation of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) which applies to care services. We saw that staff had followed guidance and were knowledgeable about submitting applications to the appropriate agencies. Where people lacked the capacity to make decisions, they were sometimes supported to make decisions that were in their best interests. However, people were sometimes given medication hidden in food without this being assessed to be in their best interest.

There was a sufficient number of staff to look after people and provide people with the care that they needed. Arrangements were made to fill 23 staff vacant posts and to reduce the usage of agency care and nursing staff.

Pre-employment checks were completed on staff before they were judged to be suitable to work at the care home.

People's risks of choking had been risk assessed and had their call bells within their reach.

Staff were aware of their roles and responsibilities in reporting incidents that had placed people at risk of harm.

People's privacy and dignity was respected at all times, including when they were supported with taking their medication and personal care. People and their relatives were involved in developing and reviewing the care plans. The majority of staff were kind and caring.

There was a process in place to ensure that people's health care needs were assessed. However, improvements were needed in relation to assessing people's pain and the management of people's behaviours that challenge others.

Staff were better supported than at our last inspection and the standard and quality of their work was kept under review. New staff received induction training to ensure they understood their roles and responsibilities. Staff training and development needs were identified and actions were taken to improve the training of staff.

People were supported to engage in hobbies and interests that they enjoyed taking part in. People were supported to maintain relationships with their relatives and make friends with each other.

Records were not always completed to provide evidence that people were always supported to eat and drink sufficient amounts.

A complaints process was in place which was accessible to people, relatives and others who used or visited the service.

People shared their views and suggestions in relation to food and their hobbies and interests. Staff were enabled to make suggestions to improve the quality of people's care.

Actions were taken to ensure that emergency lights were operating in the event of a fire. Audits were carried out in relation to people's nutritional and condition of their skin. An analysis of the incident of falls has been carried out and actions were taken to make people safer from the risk of falling.

Medication and dining experience audits had been carried out but it was unclear what actions were taken in response to the findings.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was safe.

Staff knew how to recognise and report incidents of harm.

Recruitment practices and sufficient numbers of staff made sure that people were looked after by enough, suitable members of staff.

People were supported to take their medication as prescribed and most people's health and safety risks were well-managed.

Good

Is the service effective?
The service was not always effective.

Assessments for people's pain and their mental capacity were not always in place.

Staff were trained and supported to do their job.

People's physical and mental health needs were not always met.

Requires Improvement

Is the service caring?
The service was caring.

People's privacy, respect and independence were valued.

People were included in the development of their care plan.

Staff treated people in a kind and caring way.

Good

Is the service responsive?
The service was responsive.

People participated in their hobbies and interests to promote their sense of wellbeing.

People's change of needs were responded to and their care plans were up-dated to reflect these changed needs.

There was a complaints procedure in place for people to raise their concerns.

Good

Is the service well-led?
The service was not consistently well-led.

The provider had not fully met the requirements of submitting their provider information return.

Some but not all of the audits were effective.

People and staff were enabled to make suggestions and improvement actions were in progress in response to their suggestions.

Requires Improvement

Heron House Care Home

Detailed findings

Background to this inspection

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

This unannounced inspection took place on 13 January 2015. It was carried out by an inspector, a pharmacist inspector, an expert by experience and a special advisor. 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 specialist advisor had experience of assessing people's nutritional requirements.

Before the inspection we looked at all of the information that we had about the home. This included information from notifications received by us. A notification is information about important events which the provider is required to send to us by law. We also requested the provider to complete and submit their provider information return (PIR). This is information is what the provider is required to send to us to which gives us some key information about the service, what the service does well and any improvements they plan to make. We had not received the required PIR by the time of the inspection and we took this into account when we made the judgments in this report. We also made contact with community and mental health professionals and a social worker.

During the inspection we spoke with 16 people who live at Heron House Care Home although not all of the people were able to tell us their views due to their complex communication needs. We also spoke with seven people's relatives and, 22 staff, including the home manager, her deputy manager and a regional manager. We reviewed 12 people's care records, 21 people's medication administration records and records in relation to the management of the service such as audits, policies and staff records. We also observed how staff supported people in meeting their individual needs.

Due to the complex communication needs of some of the people living at the care home, we carried out a Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experiences of people who could not talk to us.

Good

Is the service safe?

Our findings

People told us that they felt safe because they liked the staff. One person said, "I get on very well with the staff." Another person told us, "The staff are very good. I have a laugh and joke with them."

Since our last inspection we have received notifications completed by senior staff members which told us what actions were taken following events where people had experienced or were placed at risk of harm. We found that action had been taken to minimise the risk of a similar occurrence of such events and the provider had followed the correct reporting procedures. Visiting relatives said that they felt their family member was looked after in a safe way.

Staff were trained and knowledgeable in recognising and reporting incidents of harm experienced by people. They gave examples of what is considered harm and demonstrated their knowledge in following the correct reporting procedures. In addition, a minimum of one member of staff was present in the communal lounges of Wendreda and Eastwood units where incidents had occurred that posed a risk of harm to people. A member of staff told us that the presence of a staff member, "Keeps it (the unit) calm and (people) happy." A visiting relative told us that when they visited, there was always a member of staff present in the communal lounge.

During our last inspection we found that some people were placed at risk of choking. During this inspection we found that staff were aware of people's individual choking risks. This included supporting people to eat and drink and providing thickened drinks to reduce the risk of choking in response to specialist advice from a health care professional.

Before this inspection we received a concern from a whistle blower. The provider investigated their concerns and developed an action plan in response to their investigation. We found that the action plan was in place to minimise the risk of people experiencing harm due to unsafe care. Members of staff told us that they were aware of the whistle blowing policy. One staff member said, "I am not afraid at all (to blow the whistle). We can go to the manager and they are happy to listen."

People who we spoke with said that there was always enough staff on duty to meet their needs. We observed that staff had the time to provide people with their care in an unhurried way. This included when they supported people to take their medication and with eating and drinking.

A visiting relative told us, "The staff are alright but, mind you, they are always changing and [name of spouse] takes time to get to know them." They also felt that the communication between agency nursing staff and care staff could be better and gave us an example of a delay in their family member attending a follow-up health appointment and said that this had caused their family member to experience pain.

Since our last inspection, there was a high turnover of staff; 13 staff members had left their employment and there were 23 staff vacancies to be filled, 11 of which were registered nurses. Measures were taken to cover these staff vacancies which included the use of agency staff. An agency member of staff said that they had worked at the home on previous occasions to provide a continuity of care. A tool was used to determine the number of staff required to meet people's individual needs, which the home manager told us that they found it to be "useful".

Recruitment practices were in place and staff were only employed at the service once all appropriate and required checks were satisfactorily completed. Staff told us that they had these checks carried out and had attended a face-to-face interview before they started their employment.

During our last inspection we found that the provider was not compliant with Regulation 13. The provider wrote to tell us what action they were going to take. We found improvements in relation to the storage and disposal of medicines. One person told us that they get their medication when they wanted it and were satisfied with how this was done. Another relative told us that they had no concerns regarding how their family member was supported to take their medication.

People were given their medicines as prescribed although in some cases staff did not record the actual time medicines were given to people if different to those printed on the medicine record forms. This meant that people were at risk of receiving medicines too close together. Some people received their medicines in the form of a skin patch.

Good

Is the service safe?

We looked at the records made where these patches were applied and found that the site of application was recorded. This meant that the risk of damage to a person's skin was minimised as the application site was changed.

Requires Improvement

Is the service effective?

Our findings

We saw that staff had followed the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) guidance and were knowledgeable about submitting applications to the appropriate agencies. This was so that people would not have any unlawful restrictions imposed on them.

Where people lacked the capacity to make decisions, they were not consistently supported to make decisions that were in their best interests. People were sometimes given medication hidden in food and drink without this being assessed to be in their best interest. There was no documentary evidence that this had been agreed with all interested parties that this was in the person's best interests. We found the provider's policy was not being followed and we were not assured that the best interests of the person were considered in these circumstances.

This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Before our inspection a mental health professional told us that they had a lack of confidence in the ability and experience of some of the staff to manage people's behaviours that challenge others. We were not provided with assurances that staff had followed people's care plan guidance in managing their behaviours that challenge. This included including giving people comfort and reassurance before resorting to the use of 'when required' medication. During our last inspection we found that there was a lack of understanding of the ill-effects noise may have on people living with dementia. On Eastwood we found that a radio was playing loud music and there were three people who were agitated. This showed to us that there remained a lack of understanding of the ill-effects that noise may have on people living with dementia.

Where people were prescribed medicines on a 'when required' basis, for example for pain relief or to ease their agitation, we found there was insufficient guidance for staff on the circumstances these medicine were to be used. During the lunch time observation on Wendreda unit we found a person was unsettled and crying out. Our review of their care records found there was no formal assessment of the person's pain and there was insufficient guidance for staff in how to control the person's pain. A member of nursing staff advised us that the person showed facial signs of discomfort when they were being supported to change their position in bed.

A relative told us that they were dissatisfied regarding the inadequate level of support for their family member to attend a follow up health appointment. The relative told us that had noticed that their family member had experienced intermittent pain when eating and drinking. Our review of the person's care records confirmed that no action had been taken to support the person to be re-reviewed by a health care professional, since October 2014.

During our last inspection we found that people living with dementia were asked what they would like to eat, although this was in a way that they had difficulty in understanding. We found inadequate improvements have been made. Our lunch time observations on Wendreda and Eastwood unit found that staff had failed to present people living with dementia with a choice of menu in a way that they were able to understand.

This is a breach of Regulation 9 (1) (b) (ii) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

During our last inspection we found that staff were not supervised or supported to do their job. The provider wrote to tell us what remedial action was to be taken to meet the requirements of the regulation. We found that action had been taken to address our concerns because staff were supported and supervised and most had had an appraisal. Staff said that they felt supported and had attended supervision sessions with their manager. Staff who were new to the service had also attended induction training. This included supervision by an experienced colleague, for two weeks, when supporting people with their care needs.

A training and staff development plan was in place. This included training in pressure ulcer prevention, nutrition, and medication and Mental Capacity awareness. Staff told us, and their training records confirmed, that they had received recent training and had been assessed that they were competent to handle medicines. When staff were found to lack the skills to provide people with safe moving and handling, they had attended refresher training in moving and handling techniques.

Some of the people told us that they liked the food and had a menu to choose from. One person said, "They (the

Requires Improvement

Is the service effective?

staff) come around and you tell them what I want tomorrow." Another person said that the food was, "Not terribly good. (There is) enough but not to my liking." However, people told us that they had enjoyed their lunch. During our lunch time observations we saw that people were offered a choice of menu and people's individual dietary needs were catered for.

We found that people's weights were recorded and monitored and their nutritional needs were assessed. Food supplements were provided where people were assessed to be at a risk of, or who had experienced, unintentional weight loss. We also found that people were supported to access health care professionals, who were employed by the speech and language and dietician services, for their nutritional needs.

People told us, and their records confirmed that, they were supported to see their GP and have their feet treated by a visiting health care professional. Relatives confirmed that this was the case. Before this inspection a health care professional told us that they had no concerns in relation to how people's health care needs were met. They told us that staff supported people to access the GP and the community nursing service without any delay.

Good

Is the service caring?

Our findings

People had positive comments to say about the care staff. One of the people told us, "The staff are very good, they look after you and they are very caring." Another person said, "The staff are all very kind." A relative told us, "The workers see to [family member] really well. They're brilliant." Relatives told us that they visited most days and at a time when they chose to. We saw staff welcoming people's visitors and offered them a drink and a chair to sit on.

People told us that staff knocked on their doors and waited for permission before entering and we saw that this was the often case. In addition, people were supported with their personal care behind closed doors. Where a person was in a state of undress, the member of staff held the person's hand and guided them into their privacy of their own room. We also found that a person was supported by staff to speak with their children via telephone in private.

We observed medicines being given to some people during the day and saw that this was done with regard to people's dignity and personal choice. We heard staff explain to people what they were doing. We also saw that the member of staff stayed with the person while they took their medicines.

One of the people said, "They (the staff) get my things out ready for me. I then can get myself washed all over without much help." During our observations we saw people were prompted and encouraged to independently eat and drink.

The premises maximised people's privacy and dignity. Communal bathing and toilet facilities were provided with lockable doors and all bedrooms were used for single use only.

During our last inspection we found that the quality of engagement of some of the staff with people living in the home was inadequate. We found improvements had been made. On Eastwood we saw staff were kind, attentive and patient when supporting people with their food and drink and when speaking with them. We saw how people smiled and shared a joke, on an equal basis, with staff members. On Wendreda we saw that staff were also kind and attentive although this was not consistent. For example we saw there was a delay in staff attending to a person who was showing signs of being unsettled and was crying out. On Nene and Heron Court staff were seen to be kind and attentive. We saw a member of staff take time to look with a person who believed they had lost something from their handbag. We also saw staff talked to people when supporting them with their moving and handling needs with the use of a hoist and the person was settled during this procedure.

Staff listened to what people were saying and told us that, through conversations, found out about people's life stories. One person said, "I feel the staff know me and they all know my family." However, care records that we reviewed held insufficient information about people's life histories. A senior member of staff advised us that work was in progress to obtain this information.

The care plans were under review with new care plans being developed in discussion with the person, their family and health care professionals. Some of the people told us that that they were involved in the review of the care plans and day-to-day decision making. A relative told us that their family member's decision of when they wanted to get up and how to spend their day was respected.

Information about general and mental advocacy services and the complaints procedure was available in the entrance of the home. A relative told us that they had the legal right given to them to advocate for their family member.

People's confidential information was kept secure in locked rooms and was accessible to people authorised to do so. We found that staff maintained people's confidentiality when speaking with each other.

Good

Is the service responsive?

Our findings

Our review of people's care found that people's needs were assessed and work was in progress to include people's contribution to the development of these. A senior staff member advised us that work was also in progress to develop these care plans to include information about people's life histories. We found that there were records held which were recommended by mental health employees and the Alzheimer's Society. However, we found only one of these had been completed although there was insufficient information about the person's personal history.

People's care records were audited and reviewed. Changes were made in response to people's needs, including reducing the risk of falls and developing pressure ulcers.

During our last inspection we found that people did not have access to call bells. During this inspection we found that people had access to call bells to use if they needed the assistance from staff and these were responded to. During our last inspection we found that people's wellbeing needs were not being met due to the lack of provision of meaningful hobbies and interests. The provider wrote to tell us what remedial action would be taken to improve this. We found improvements had been made. People told us that they usually had enough to do although one person said that "They (people) need stimulation more than anything else." However, another person said that they did not get bored. We saw people were taking part in table skittles, going outside for a walk or playing a game with a member of care staff. Other people were encouraged to hold dolls and soft toys and were relaxed in doing so. Music was playing and we heard and saw people singing along. A member of staff told us that some people attended religious services which were held at the care home.

People were supported to maintain contact with their family and make friends with other people. During our visit to Eastwood we saw that two people were talking to each other in a friendly way while listening to music and having their mid-morning drink and snack.

People told us that they knew who to speak with if they had a concern or complaint to make. One person said, "I can't find a fault with it (the care home). I would tell them (if needed)." Another person said they knew where to find and speak with the manager. However, one relative said that they felt they were not being listened to in respect of their family member's care. We drew this to the attention to a senior member of staff to take action. Our review of the record of complaints found that people's concerns and complaints were responded to and action was taken to the satisfaction of the complainant. We saw there were no recurring themes for the provider to take improvement actions in relation to the management of the service.

Requires Improvement

Is the service well-led?

Our findings

During our last inspection we found that the provider was not meeting the requirements of Regulation 10(1) (a) (b). The provider wrote to tell us what remedial action was to be taken to be to be complaint with the regulation. During this inspection we found that some improvements were still needed to meet the requirements of the regulation.

We looked at the audits of the medication administration records, which were completed during December 2014 and found these identified some stock discrepancies. However, we were unable to find what action was taken to investigate these errors. This lack of action posed a risk of people not receiving their medication as prescribed. During our last inspection we found that improvements were needed in relation to the quality of people's dining experiences. In December 2014 a senior manager had completed a dining experience audit. The audit identified that people were not always offered choices of what they would like to eat in a way that they could understand. We found no action had been taken to address this on-going issue.

This is a breach of Regulation 10(1) (a) (b) (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Before the inspection we requested a completed provider information return (PIR) to be sent to us. We found electronically held evidence that the provider had received their PIR. However, we found no record to confirm that the PIR had been completed and submitted to us as required. This gave us a lack of assurances that the home was consistently being well-managed.

Since our last inspection the registered manager had left although their name remains on our register because we have not yet received their application to cancel their registration. The provider had alternative management arrangements in place to support this situation. This included a temporary home manager who was supported by their manager and the deputy manager. Members of staff described the home manager to be, "Firm but fair." Another staff member told us that, due the leadership style of the manager, "The (staff) dynamics are much better. Staff are happier and if they are happy, they (people) are happy. We can go to the manager and they are listening to us." Staff and a social care employee told us that there had been an improvement in the management of the home. People knew who the manager was and some were able to tell us the manager's name. A relative said that they were unsure who was managing Heron House Care Home but said, "I know where the office is. I would go and speak to someone there." Staff told us that they saw the manager on the units and daily records confirmed that this was the case.

Staff were aware of their expectations of their roles and knew who to report to, for instance care staff reporting to nursing staff. Where staff were not meeting the expectations of their role, there were staff disciplinary and supervision procedures in place to review the performance of those members of staff.

Audits were carried out in relation to people's nutritional needs and their condition of their skin. Actions were taken in response to findings, which included increasing the calorific content of people's food. When people had acquired a pressure ulcer, an analysis was carried out to find out the reason for people having developed these. We saw that action was taken to increase the frequency of times when people were to be supported to reposition themselves in bed. In addition, an analysis was carried out to find the cause of why people experienced falls and action was taken to reduce the risk of people falling. This included the provision of special equipment ('crash mats') and for an increase in staffing numbers to supervise people more closely.

Staff told us that they were given opportunities to develop their career. In addition, a staff training and development plan was in place for staff to improve their understanding in supporting people with nutritional and mental health needs.

Staff were aware of the purpose of looking after people. One member of staff told us, "We (staff) always put the people first. We're here for them." Members of staff told us that they had made suggestions to improve the standard and quality of people's care. This included offering people the choice of sandwiches at supper time. Our review of the menus demonstrated that these changes had taken place. We saw that staff respected people's dignity, privacy and demonstrated an improvement, since our last inspection, in how they cared for people they looked after.

Members of staff advised us that arrangements were in place to improve the links with the local community. This

Requires Improvement

Is the service well-led?

included the recruitment of volunteers and invitations were sent to local educational establishments for school children and college students to visit people in the home in the future.

Since our last inspection people were asked for their views in relation to the menu and their interests and hobbies. We found that arrangements were made for people to attend a menu planning meeting to contribute to the planning of the menus. In addition, we saw that staff had discussed with the management team the range of hobbies and interest that people would like to take part in and to arrange a programme in response to people's suggestions. Relatives told us that they had attended meetings and had received copies of the minutes of these. One person said that they had raised a concern about the presentation of the gardens and driveway to and from the home. The manager told us that arrangements were in place to address these issues. We were advised that the next relatives'/ 'residents'' meeting was due to be held during January 2015 and this was to be advertised throughout the home.

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
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services **Regulation 9 (Regulated Activities) Regulations 2010 Care and welfare.** **People who use services were not protected against the risks associated with inappropriate care. This was due to inadequate planning, assessment and delivery of care to appropriately meet their individual physical and mental health needs.** **Regulation 9 (1) (b) (ii).**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision **Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Assessing and monitoring the quality of service provision.** **People who use services were not protected from unsafe and inappropriate care due to inadequate quality monitoring systems. This was because actions were not taken when risks and substandard care practices were identified during the quality monitoring of the service.** **Regulation 10 (1)(a)(b)(3).**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment **Regulation 18 of the Health and Social Care Act 2008 (regulated activities) Regulations 2010. Consent to care and treatment.**

This section is primarily information for the provider

Action we have told the provider to take

People who use the service were not protected from staff as action was not being recorded on decisions taken in people's best interest.

Regulation 18.