Four Seasons Homes No.4 Limited

Heron House Care Home

Inspection report

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Ratings

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

Overall summary

We carried out an unannounced comprehensive inspection of this service on 13 January 2015. A breach of three legal requirements was found. These were in relation to people's right to consent, their care and welfare and the management of the home.

After the comprehensive inspection, the provider wrote to us to say what they would do to meet the legal requirements in relation to assessing and planning and providing people with the care to meet their individual needs; quality assurance and making sure how people's rights to consent were valued.

Following our comprehensive inspection we received information of concerns in relation to people's medicines and the level of activities provided that were meaningful to people.

We undertook this unannounced focused inspection on 27 July 2015 to check that the provider had followed their plan and to confirm that they now met legal requirements. We also undertook the inspection to check if people health and social needs were being met. We found that the provider had followed their plan which they had told us would be completed by the 31 May 2015 and legal requirements had been met.

This report only covers our findings in relation to this topic. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Heron House Care Home on our website at www.cqc.org.uk.

Heron House Care Home is registered to provide accommodation and care, including nursing care, for up

Summary of findings

to 92 people, some of whom have mental health needs. The home is arranged in four named individual units, Heron Court, Wendreda, Eastwood and Nene. At the time of the inspection there were 70 people living at the home.

A registered manager was not in post at the time of our inspection. There has not been a registered manager in post since December 2014 when their application to voluntarily cancel their registration was approved. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The provider had appointed a new manager who was applying to be registered.

Action had been taken in relation to making sure people's rights in making or being supported with making decisions about their care were protected. People's mental capacity was assessed and when people were assessed not to have mental capacity, their care was provided in their best interests. This included being given their prescribed medicines hidden in food and drink.

Action had also taken regarding people's care and welfare. People were assessed for pain and they were given medicines when they experienced pain. Staff had an understanding of the individual communication and behavioural needs of people living with dementia. People were assessed and treated by a range of staff who were employed by health care services.

Some of the people said that they had enough to do as they liked to watch television and read. However, there was a lack of meaningful day-to-day activities to promote people's sense of well-being. Some people were not supported to take part in activities that were meaningful to them and this had a negative effect on their sense of well-being. Work was in progress to improve how people spent their day, and more staff were being recruited.

Action had been taken to improve the quality assurance systems. Audits were in place to improve the management of people's medicines and people's care records. Learning had taken place in relation to errors in the recording and administration of people's medicines.

Each of the four units were managed by a designated member of staff who were responsible for making sure that staff provided people with safe and good quality care and care that respected their dignity. We found that the leadership of two of the four units had not made sure people that were always kept safe and that they received quality and effective care.

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 effective?
The service was effective.

Action had been taken to ensure that people were supported in making decisions about their care. People's rights were protected.

Action had been taken to ensure that people's health care needs were assessed and that that they were supported in keeping well.

This meant that the provider was now meeting the legal requirements.

Good

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

There was a lack of provision of activities, hobbies and interests that were meaningful to people.

Requires Improvement

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

There was a lack of supervision of staff to make sure that people were always protected from unsafe, ineffective care that did not consistently value their dignity.

Action had been taken to improve the audits in relation to medicines and people's dining room experiences.

This meant that the provider was now meeting the legal requirements.

Requires Improvement

Heron House Care Home

Detailed findings

Background to this inspection

We undertook an unannounced focused inspection of Heron House Care Home on 27 July 2015. This inspection was undertaken to check that improvements to meet legal requirements planned by the provider after our comprehensive inspection of 13 January 2015 had been made. The focused inspection was undertaken to check that the management of the home had systems in place to improve the quality and standard of people's care and that people received care that met their individual needs.

The inspection team inspected the service against three of the five questions we ask about services: is the service effective; is the service responsive and is the service well-led. This is because the service was not meeting legal requirements in relation to these questions and also because of concerns we had received since 13 January 2015.

The inspection was undertaken by two inspectors and a pharmacist inspector. Before the inspection we looked at all of the information that we held about the home. This included information from a local authority contracts manager; information from the provider's action report, which we received on 29 May 2015, and information from notifications received by us. A notification is information about important events which the provider is required to send to us by law.

During the inspection we spoke with 12 people, four people's relatives, a visiting health care professional and a visiting social care professional. We also spoke with a regional director, the manager, the deputy manager, and a member of catering staff, an activities co-ordinator, six registered nurses and a member of care staff. We looked at 11 people's care records and 15 people's records in relation to their medicines. We observed people's care to assist us in our understanding of the quality of care people received.

We also used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

Good

Is the service effective?

Our findings

At our comprehensive inspection of Heron House Care Home on 13 January 2015 we found that assessments were not in place to determine people's mental capacity to make decisions about their care. Decisions about their care were made on their behalf without such an assessment in place.

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

During our focussed inspection of 27 July 2015 we found that the provider had followed the action plan they had written to meet shortfalls in relation to the requirements of Regulation 18 described above.

We found that people's mental capacity to make decisions had been assessed. Where people were assessed not to have capacity, they were supported in the decision making process and care was provided in the person's best interest. This included care with personal care, medicines, which included medicines disguised in food and drink, and end-of-life decisions. A visiting social care employee said, "Staff discussed [name of person's] care with her. She made the decision to stay in bed and not be hoisted (moved by equipment) every day." We saw a person's decision about when they wanted to take their prescribed medicines was respected and another person's decision about when they wanted to eat their lunch was also respected. We saw that people's choice of what they wanted to drink and eat was not always offered. The manager advised us that he had taken action for staff to attend training in the application of the Mental Capacity Act 2005.

At our comprehensive inspection of Heron House Care Home on 13 January 2015 we found that assessments for the management of people's pain were not always in place. This was a breach of Regulation 9 (1) (b) (ii) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

During our focussed inspection of 27 July 2015 we found that the provider had followed the action plan that they had written to meet shortfalls in relation to the requirements of Regulation 9 described above.

Action had been taken to assess people's pain and they were supported to take their medicines to ease and control their pain. People's experience of pain was assessed and their records demonstrated that people were prescribed medicines to control and manage their pain. A relative said, "My wife does take tablets and they are paracetamol for the pain."

At our comprehensive inspection of Heron House Care Home on 13 January 2015 we found that people's mental health needs were not always being met. This was a breach of Regulation 9 (1) (b) (ii) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

During our focussed inspection on 27 July 2015 we found that the provider had followed the action plan that they had written to meet shortfalls in relation to the requirements of Regulation 9 described above.

We found that people's mental and physical health needs were met. Music was played at a low level to reduce the risk of people, who were sensitive to noise, from becoming unsettled. Their complex communications needs were met when making decisions about what they wanted to eat. The menu choices were presented on plated food for the person to see and smell and make their decision from this sensory experience. The activities co-ordinator described how they engaged with people living with dementia and entered their world of reality and supported the person's identity (or 'personhood').

People were also supported to be assessed and treated by health care employees. A relative said, "Health wise, my father is very good. They've taken him to the (GP) surgery for his diabetes (check-up). They (staff) began to quickly realise to restrict the sugar in his diet." Other health care employees included dieticians, occupational and speech and language therapists, chiropodists and falls co-ordinators. On the day of our inspection an optician was visiting people to assess their eyesight. However, we found that no action had been taken for a person to be assessed by a heath care professional in relation to the change into the increased size of their feet, which can be a sign of a change in people's health.

Requires Improvement

Is the service responsive?

Our findings

Following our inspection of 13 January 2015, we received concerns that people were not provided with hobbies and interests that were meaningful to them. During our inspection we found this was sometimes the case.

A programme of activities was developed and this included forthcoming events to include monthly religious services, 'bingo' and a coffee morning to raise money for charity. Some of the people said that they never got bored. One person said, "I don't get bored because I have a lot of visitors." Another person told us that they liked to read, listen to the radio and watch the television in their room. We were also told by another person that they had enjoyed taking part in an arts and crafts activity. The activities co-coordinator said that this type of activity helped people with exercising their hands as well as being enjoyable.

A relative said, "Sometimes I take her (family member) to Peterborough. My daughter brings in fish and chips every Wednesday night. But there is not a lot going on here." Another relative said, "Sometimes I don't think he (family member) has enough to do." We saw that the care and nursing staff interacted with people only when they were supported with their care. This included when they were supported with food and drink.

The short observational framework for inspection (SOFI) showed that there were few positive interactions between staff and people in the lounge during the time observed. We saw one the people was 'looking' at magazines but staff did not encourage or discuss these with the person. Another person was seated near staff but they did not talk with the person or include them in their conversations.

On Wendreda unit we saw a person who was the named, 'Resident of the Day.' A registered nurse explained that the scheme enabled the person's care plan records to be reviewed with the person, if possible, and their relatives. However, we were told that there was no other activity or hobbies and interests provided to be in keeping with the spirit of the scheme. We also saw another person was walking about and speaking with visitors, people and staff but was repeatedly told to sit down by staff and visitors. The person was not provided with an activity based on their strength of wanting to walk and talk and we saw that they became anxious and was disinterested in eating their lunch.

In the lounge of Wendreda unit a radio programme was playing music. However, we saw that people were not showing positive signs of well-being as they were staring into space or sleeping. In one of the communal lounges on Heron Court, a television was on. Two people were seated in front of the television and were asleep. The activities co-ordinator was newly appointed and described the activities that she supported people with. This included board games, manicures, going to the local town and listening to people's memories. They told us that there was recruitment of another activities co-coordinator. The manager confirmed that this was the case. The manager also said that they had plans in place to gain advice from community and hospital based mental health care employees. The aim of this was to improve the range of hobbies and interests provided for people to take part in.

Requires Improvement

Is the service well-led?

Our findings

At our comprehensive inspection of Heron House Care Home on 13 January 2015 we found that some of the quality assurance audits were ineffective to ensure that people were kept safe and were in receipt of quality care.

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

During our focussed inspection of 27 July 2015 we found that the provider had followed the action plan they had written to meet shortfalls in relation to the requirements of Regulation 10 described above.

We found that people's medicines were kept secure at all times and audits were carried out in relation to people's medicines. The lock to a medicines storage room door had been mended and was made secure. In addition, action had been taken to ensure that staff were reminded of their roles and responsibilities in maintaining medicines records. The deputy manager said, "Through the medicines audit, it said something hadn't been signed. So I went to check it as part of my informal audit."

Dining room audits had been carried out and we found that there was an improvement in people's dining room experiences, particularly on Eastwood unit. Staff offered people choices of food and condiments: tables were provided with written menus and there was a calm atmosphere throughout the lunch time.

After our comprehensive inspection of Heron House Care Home on 13 January 2015 we had received concerns in relation to the management of people's medicines. Due to errors, some people had not received their medicines as prescribed. During our inspection of 27 July 2015 we found that learning had taken place and people were given their medicines as prescribed. This included the recording of the application and removal of patches of medicines, so that people were given the correct amount of medicines that was delivered through these patches.

The local authority contracts manager told us that the management of the home had improved since our comprehensive inspection in January 2015. The home had been without a registered manager since December 2014 and interim management arrangements had been put in place pending the successful appointment of a new manager. Members of nursing and catering staff told us that they had noticed an improvement in the overall management of the home and the atmosphere of the home had improved, due to the leadership styles of the interim managers.

The newly appointed manager commenced their new role on 23 June 2015 and their application to become registered with CQC was in progress. People, staff and relatives knew who the new manager was, said they had seen him walking around the home, observing and talking to people. We, too, saw his presence around the home. Staff members described the manager to be fair and that he listened to what they had to say. A registered nurse gave an example about this; they told us that they had shared their concerns with the manager in relation to staffing, and that a meeting was to be held on 29 July 2015. The manager told us that action was taken in response to the concerns and a meeting was arranged. This was when staff were to be reminded of their responsibilities in being punctual in arriving for work and to improve their communication with the management of the home, if they were unable to attend for work.

On Eastwood unit we saw that staff had failed to follow a person's care plan and had applied unsafe moving and handling techniques. We also saw a person had become in a state of undress and we took action to preserve their dignity, as members of staff had failed to do so. We also found that there was no action taken in response to a person's ability to wear their footwear, due to a (possible) change in their medical condition. This meant that there was inadequate leadership of Eastwood unit to make sure that people were consistently provided with safe, effective and quality levels of care.