Four Seasons (Bamford) Limited

Heywood Court Care Home

Inspection report

Green Lane
Heywood
Rochdale
Lancashire
OL10 1NQ

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29 June 2016

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Inadequate**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**

Summary of findings

Overall summary

This inspection took place on the 29 June 2016. This was an unannounced focused inspection undertaken due to concerns that had been raised with us since our last inspection on 17 December 2015.

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

Heywood Court Care Home is a purpose built detached home close to the centre of Heywood. Accommodation is provided over three floors. The home is registered to provide accommodation and personal care for up to 45 people. On the day of our inspection 33 people were living at the home.

The service had a registered manager in place at the time of our inspection. 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.

During this inspection we found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

We found a number of items were being stored in two fire escapes that should be kept clear for use in an emergency situation. We also found a number of door guards (specially designed equipment to keep doors open that close when the fire alarm sounds) were not safe as the batteries were buzzing to suggest they required replacement. This meant some doors may not close in a fire situation.

One person's records we looked at showed they were assessed as a high risk of choking, however an oral assessment, level of need and care plan had not been completed placing the person at risk of choking.

Records for one person showed they were at risk of weight loss, however they had not been weighed on admission and there was no evidence of further weights being undertaken.

Food and fluids charts that were in place did not adequately provide information relating to the intake of diet for people, for example if they had eaten a full portion or half a portion. This meant it would not be possible to monitor if people were taking adequate diet to maintain a healthy weight.

The service could not demonstrate that people who were at risk of developing pressure ulcers were receiving the required amount of positional changes to protect their skin from breaking down.

People were at risk of incorrect moving and handling procedures as they were not adequately assessed in relation to the type of equipment to be used and how to use this.

At the commencement of our inspection at 6am we found 13 people were up and dressed. Some people were sleeping in chairs and one person was dressed and asleep on their bed. Care plans and daily notes did not always provide evidence why people were up early. One staff member told us there was an expectation that night staff got people up early in the morning.

Care plans we looked at did not always reflect people's choices about the amount of baths/showers they had a week. Records we looked at showed people were receiving one shower or bath a week, some of whom were incontinent and would benefit from more regular bathing.

One person who had been discharged from hospital on end of life care did not have an end of life care plan in place. This meant their wishes in the event of their death would not be met as these were not known to the staff.

Terminology used in some care plans was negative and disrespectful of people who used the service, for example 'wandering' or 'wander some'. One staff member we spoke with described a person as 'a wanderer'.

All the staff we spoke with knew their responsibilities in relation to safeguarding people who used the service.

Toiletries contained people's names so that they remained personal to them. We found people had adequate supplies of toiletries in their rooms.

People who were able to talk to us were complimentary about the staff members and meals provided within the service.

Bedrooms we looked at were clean, tidy and had been personalised with people's own belongings.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

The service could not demonstrate that people who were at risk of developing pressure ulcers were receiving the required amount of positional changes to protect their skin from breaking down.

People were at risk of incorrect moving and handling procedures as they were not adequately assessed in relation to the type of equipment to be used and how to use this.

Bedrooms we looked at were clean, tidy and had been personalised with people's own belongings.

Is the service effective?

Requires Improvement

The service was not always effective.

People who used the service who were at risk of weight loss were not always adequately monitored to ensure they maintained a healthy diet and weight.

Where people were being deprived of their liberty the registered manager had taken the necessary action to ensure that people's rights were considered and protected.

We saw people were offered drinks on a regular basis throughout our inspection and noted people had jugs of water or juice in their rooms.

Is the service caring?

Requires Improvement

The service was not always caring.

Thirteen people who used the service were awake and dressed at 6am, some of whom we could not find evidence to inform us why they were up so early. One night staff confirmed they were told to get people up early.

People who used the service were not always treated with dignity and respect. One staff member referred to a person as 'a

wanderer'.

We observed that staff were patient, unhurried and caring when providing support

Heywood Court 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 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.

We undertook a focused inspection on 29 June 2016 due to concerns that had been raised with us since our last inspection. The concerns raised were around; night staff getting people up from 04:30am, bathing of people who used the service, moving and handling, fire safety, lack of support at mealtimes, inadequate fluids being provided, staff members attitudes towards people who used the service, deprivation of liberty safeguards (DoLS), care plans and risk assessments.

The inspection team consisted of two adult social care inspectors. A Health and Safety Officer from Rochdale Borough Council was also inspecting the moving and handling equipment in the service on the day of our inspection.

We contacted the local authority safeguarding team, the local commissioning team and the local Healthwatch organisation to obtain views about the service. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. The local commissioning team responded to us to inform us of the concerns that were raised during their recent quality assurance visit. We considered these concerns when planning this inspection. Healthwatch told us they had not received any concerns regarding the service.

During the inspection we carried out observations in all public areas of the home and undertook a Short Observational Framework for Inspection (SOFI) during the lunchtime meal period. A SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We spoke with three people who used the service; some people who used the service were unable to speak to us due to their capacity and understanding. We also spoke with five staff members, deputy manager, registered manager and regional manager. We looked at the care records for ten people who used the service.

Inadequate

Is the service safe?

Our findings

We examined ten care files during our inspection. We saw that risk assessments had been completed for issues such as moving and handling, falls and nutrition. The risk assessments were completed to keep people safe and not restrict what they wanted to do.

One person's records we looked at showed they had been assessed as a very high risk of developing pressure ulcers. We looked at the positional change charts in place for this person which showed they were to have pressure relief every two hours. Records we saw showed that on six occasions from the 12 May 2016 they had their position changed every three hours (instead of two) and seven occasions when their position had been changed every four hours (instead of two). We also saw one day when the chart had not been completed from 12:30pm onwards to the next day and another day when it had not been completed from 13:15pm to 21:00pm. This meant that the service could not demonstrate that people received the positional changes required to protect their skin from breaking down.

Another person's records we looked at showed they had been assessed as a high risk of choking and required full assistance with all aspects of nutrition. The oral assessment, level of nutritional needs and care plan contained within the care file had not been completed. This meant care staff had no direction in relation to minimising the risks of choking for this person or the support they required to eat, therefore placing the person at risk.

These matters are a breach of Regulation 12 (1) and (2)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as people who used the service were not safe due to the identified risks not being mitigated.

Prior to our inspection we received concerns that people who used the service were placed at risk in relation to moving and handling; in particular the use of slings. On the day of our inspection a Health and Safety Officer from the local authority was in attendance at the service to undertake checks on the moving and handling equipment within the service. They have provided the service with their own outcome of findings which included; not all equipment (such as hoists and slings) had been checked for safety on an annual basis; the Health and Safety Officer instructed that these were removed from use immediately (hoists and slings that had been checked were still available) and until such time as they had been inspected and deemed safe to use, a lack of policies and procedures in place for 'in situ' slings (slings that are moulded with less excess material so that they can be left in place for up to three to four hours, as per manufacturers guidance), risk assessments and staff training required for the use of 'in situ' slings.

Staff told us they had received training in manual handling, this included a practical assessment and were able to describe different sizes of slings and how they should be used.

We looked at one person's moving and handling care plan. We saw that they were unable to weight bear and had been assessed as requiring the use of a hoist and sling when moving and handling. We saw no assessment had been undertaken in relation to the type of sling that would support the person and be

suitable for use. Care plans did not inform or direct staff on the type of sling to be used and how this was to be correctly fitted to the hoist to ensure the person's safety at all times. This meant that the person was at risk of injury from the incorrect use of slings and hoists.

These matters are a breach of Regulation 12 (1) and (2)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as risks to the health and safety of people who used the service when moving and handling were not always fully assessed.

During our inspection we found 23 boxes of continence pads stored in a fire escape on the second floor landing. We also found 59 boxes stored in an unlocked empty bedroom, which was located directly in front of the fire door leading to where the other boxes had been stored. We also saw a number of items being stored in another fire escape route on the ground floor. We spoke with a senior carer who was nominated as the fire warden. They were aware the items were being stored in the fire escape but told us, "I don't know who deals with that." They also told us they knew this was a fire risk.

We spoke with the registered manager regarding the fire risk of these items being stored. They told us they would clear these immediately. Later on our inspection we saw that all items had been removed from the fire escapes and the door to bedroom 31 had been locked.

Throughout our inspection we heard a number of door guards (specially designed equipment to keep doors open that automatically close when the fire alarm sounds) buzzing. We asked a staff member why they were buzzing and was told that the batteries were going in them and needed replacing. This meant there was a risk that in the event of a fire situation, bedroom doors may not close to protect people and contain a fire.

We also found that a shower room that was out of order was being used to store a number of items that were potentially combustible and the door to this room was not locked. This was a risk to people who used the service.

These matters are a breach of Regulation 12 (1) and (2)(a)(b) and (f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as people were placed at risk in a fire situation when using fire escapes and potentially combustible items were inappropriately stored.

All the people we spoke with told us they felt safe living at Heywood Court Care home. One person told us, "I feel safe, it's much better than the last place I lived."

Staff we spoke with told us they had received training in safeguarding and whistleblowing. All staff we spoke with were able to tell us about the signs of abuse, what they would do if they suspected abuse and who they would report it to. Staff were confident the registered manager would take any matters they raised seriously and would deal with any suspected abuse immediately.

The service had a safeguarding adult's policy, this gave staff clear examples of the types of abuse and signs that they needed to observe for and report on. The service had reported any safeguarding issues in a timely manner to the local authority and the Care Quality Commission.

The home had two shower areas and two bathrooms. On the day of our inspection we found that one shower and one bathroom were out of order. The registered manager told us that refurbishment had started on the bathroom and that the shower refurbishment was planned for the next couple of months. This meant there was one bathroom and one shower room available for 33 people at the time of our inspection. Prior to us leaving the service, we were given written confirmation that the bathroom being refurbished would be

back in operation by the 8 July 2016 which would mean from this date there would be two bathrooms and one shower room available. The action plan the registered manager sent us on the 8 July 2016 showed that some work had been completed in the bathroom, however the bath was now due to be fitted on the 11 July 2016. We received confirmation on the 12 July that the bathroom would be available for use from lunchtime on the 13 July 2016.

All the staff we spoke with told us they had received training on infection control and knew their responsibilities in relation to this.

We looked around the home and found all communal areas, toilets and bedrooms to be clean, tidy and free from offensive odours. All areas were bright and well decorated and furnishings were in good condition. There were two lounges on the ground floor that had access to the garden. The garden had tables, chairs and parasols so that people could enjoy the garden if they wished. We looked in a number of bedrooms and found these were clean and tidy and most people had brought personal items in from home.

Prior to our inspection we had received concerns that people did not have an adequate supply of toiletries and that people's toiletries were being used on others. During our inspection we noted one shower room contained a can of shaving foam and three different types of shampoo. The shampoo contained the names of whom they belonged to and these should have been returned to their bedroom to avoid the potential of communal use. When we later checked the shower room, these items had been moved. We also checked that people had toiletries in their bedrooms; we found adequate supplies of toiletries were available in the rooms we checked.

Requires Improvement

Is the service effective?

Our findings

People told us they liked the food. One person said "It's nice." Another said that one staff member "makes lovely porridge."

During the breakfast meal service we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We observe breakfast in the downstairs dining room. It was relaxed and calm. There was a member of staff responsible for the dining experience. We saw that people were offered choices and that the staff member's supporting them knew their likes and dislikes. The tables had table cloths and a menu that gave information about the meals for the day. We saw that people were offered porridge or cereal and toast and jam or egg on toast. There were two cold drinks machines in the downstairs dining room, one with juice and one with water. During the inspection we saw people were offered drinks regularly and jugs of juice were left in the lounges.

Staff were aware of people's dietary needs including those people who required soft diets, fortified foods and who had allergies. We were told this information was also given to the cook.

Records we looked at showed most people had been weighed on a regular basis and the service had contacted a dietician or speech and language therapist if they had concerns. However, one person's records we looked at showed they required full assistance with their nutrition to maintain a healthy and balanced diet. However, records showed that they had not been weighed on admission and there was no other documented evidence that they had been weighed since. This meant the service had no means of assessing if the person was losing weight.

The service had food and fluid charts in place for staff to document what people had eaten and drunk throughout the day. This was particularly important for those people who were at risk in relation to their dietary and health needs such as risk of choking, weight loss and dehydration. We looked at a large number of these and found that whilst they had been used and food was documented (e.g., fish, chips and mushy peas), it did not state how much food the person had consumed, for example, full portion or half portion. This meant that for those people at risk of losing weight, there would be no means to assess if the person was taking adequate diet to maintain a healthy weight.

These matters are a breach of Regulation 14 (1) and (4)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the service did not adequately monitor the dietary intake and weight of people who used the service who were at risk of weight loss.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. Then they lack mental capacity to take particular decisions, any made on their behalf must be in their best interest and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

Prior to our inspection we had received concerns that DoLS that were in place for people who used the service were not being followed by staff members. Staff we spoke with told us they had received training in MCA and DoLS. All the staff we spoke with demonstrated an understanding of MCA and DoLS and were able to explain how they gained people's consent to the support they were providing.

Records we looked at showed that people had been assessed in relation to their capacity. These assessments had been undertaken by the relevant and appropriate people and had involved the person and their family. We also saw that best interest meetings had been undertaken for those people who lacked capacity to consent. A 'best interest' meeting is where other professionals, and family if relevant, decide the best course of action to take to ensure the best outcome for the person using the service. We saw that the service had involved external health professionals in their decision making process and acted in the best interest of the person being assessed.

Requires Improvement

Is the service caring?

Our findings

Prior to our inspection we had received concerns that people who used the service were being woken very early in the morning to be bathed and dressed. We therefore commenced our inspection at 6am. We found 13 people were up and dressed, some of whom were in the main lounges and some were in their bedrooms. We were told that three of the 13 people were able to get up and dressed themselves; however the other ten people required assistance. We spoke with the senior carer on duty to ask what time they had started to get people up and dressed. They told us they had started earlier that morning, around 05:50am as people had been unsettled. This meant they had washed and dressed ten people within ten minutes. When we questioned this the senior carer could offer no explanation but maintained they started at 05:50am.

We looked in a number of bedrooms. We saw one person was dressed and asleep on their bed. We spoke with a staff member regarding this. They told us if the person got dressed they usually settled and went back to sleep. Two other people were asleep in their comfy chairs; one was still in their night clothes. The same staff member told us one person had recently moved into the service and was very restless at night time. All the people that were up and dressed had been given a drink.

One person told us "I can choose [when to go to bed or get up], they [staff] get you up when you want" another person said "I get up myself." Another person told us they had got up at 6 o'clock on the morning of our inspection; "Because I thought they were all up, so I got up." However, the same person told another inspector, "I was woken up at 5:30am. I would like to stay in bed longer."

We asked one staff member if there was an expectation that night staff got people up and dressed before the day staff arrived, they told us there was this expectation to get people up but did not tell us if this was by day staff or the registered manager. Other staff members told us they did not wake people up. One said "I leave them until they wake up." Staff members also told us that it was documented in people's care plans that they wished to get up early.

We looked at a total of nine care plans to check what we had been told. We found some care plans documented the person liked to rise early in the morning, although daily notes did not always reflect what time they had risen and if they had been restless or unsettled during the night. However, one person's care plan documented, "[Name of service user] loves her bed. She has a restful sleep, waking to use the toilet." This care plan was reviewed on the 21 June 2016 which stated, "[Name of service user] sleeps well at night time." We found no evidence to explain why this person was up and dressed at 6am on the morning of our inspection. Another person's care records documented, "If [name of service user] feels that 07:30am is too early he will tell staff." We found this person was up and dressed when we commenced our inspection at 6am. Upon checking their daily notes, we noted staff documented, "Bit unsettled at the start of shift but then settled and slept well." This did not provide evidence why this person was up and dressed at the start of our inspection. We spoke with the registered manager about the amount of people we found up and dressed at 6am. They could not offer us any explanation why they were up. The regional manager told us they would address this through increased early morning visits by the registered manager.

Prior to our inspection we were also informed of concerns that people who used the service were not being bathed or showered frequently enough. One person we spoke with told us they could bath or shower when they wanted to. "I prefer a shower; I want to do it myself." One staff member we spoke with told us, "Night staff do two showers, day staff do two showers on each floor, per day/night." However on the morning of our inspection we were told by one staff member that no one had received a bath or shower that morning and everyone had been washed.

We looked at the personal hygiene records for four people who used the service. These consisted of care plans and personal hygiene forms completed by the care staff. Records showed that people were receiving one shower or bath per week, some of whom were incontinent and required full support with their hygiene needs. Care plans we looked at did not always reflect the person's choice in regards to how many baths/showers they would like each week; there was no evidence to show the person had been involved in the decision making process. This meant people who used the service may not be receiving the amount of baths/showers they would like or that they were used to.

Records we looked at showed that one person had been discharged from hospital on end of life care. However we noted that the end of life care plan had not been completed. We spoke with the registered manager regarding this. They told us they had instructed a senior care staff to write the end of life care plan and did not realise this had not been completed. This meant that the end of life wishes of this person had not been discussed with the person, their family or any other person important to them. It also meant the service would not know the persons wishes in regards to funeral arrangements etc. in the event of their death.

These matters are a breach of Regulation 9 (1) and (3)(a) and (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as care plans were not person centred to reflect people's wishes at the end of their life. Care plans did not reflect people's wishes or needs in relation to personal hygiene, particularly for those who were incontinent.

Prior to our inspection we received concerns that people who used the service were not always treated with dignity and respect.

People we spoke with were complementary about the staff. People told us staff were "Very good" and "They are very nice." Another person said "I don't dislike any of them." They pointed to a staff member that was offering people drinks from a trolley and told us "She's lovely." One person told us the registered manager was "Nice."

We observed that staff were patient, unhurried and caring when providing support. One staff member told us "I love working here." One staff member described how they communicated with a resident that doesn't use words. They told us " [resident] smiles, that's a lot, I know I have helped"

Some of the records we looked at, such as care plans, referred to people as wandering or wander some and called pressure mats (mats used to detect if someone got out of bed) 'wander mats'. One staff member who we spoke with on the morning of the inspection pointed at a service user and stated "She is up because she is a wanderer." This suggests that people had no purpose in what they were doing or where they were going and does not promote respectful attitudes amongst staff members. We spoke with the staff member concerned and explained this was not respectful and passed our concerns on to the registered manager and regional manager. They told us they would address these concerns immediately by arranging for more training for the staff members.

These matters are a breach of Regulation 10 (1) and (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as people were not always treated with dignity and respect and terminology used in care plans was sometimes negative.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Care plans were not person centred to reflect people's wishes at the end of their life. Care plans did not reflect people's wishes or needs in relation to personal hygiene, particularly for those who were incontinent.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were not always treated with dignity and respect and terminology used in care plans was sometimes negative.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The service did not adequately monitor the dietary intake and weight of people who used the service who were at risk of weight loss.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People who used the service were not safe due to the identified risks not being mitigated. Risks to the health and safety of people who used the service when moving and handling were not always fully assessed. People were placed at risk in a fire situation when using fire escapes and potentially combustible items were inappropriately stored.

The enforcement action we took:

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