# Four Seasons (Evedale) Limited

# Heath House

**Inspection report**

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## Ratings

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

## Overall summary

This inspection took place on 22, 23 and 29 April 2015. The inspection was unannounced.

We last inspected Heath House in December 2014 when we found the provider had breached the Health and Social Care Act 2008 in seven regulations. We found that people were not safe as there were insufficient staff and medicines were not well managed. People were not receiving effective care as they were not being supported to eat and drink enough, their health and personal care needs had not all been attended to and the requirements of the Mental Capacity Act 2005 had not been met. The provider was not caring for people adequately and we found people's privacy and dignity had not been protected. People and their relatives could not be certain that complaints would be investigated and action taken to resolve their concerns. The systems in place to assure people would receive a high quality and safe service were inadequate. Following the inspection in December 2014 we spoke with representatives of the provider. We issued seven compliance actions and two warning notices. These are formal ways we have of telling providers they are not meeting people's needs or the requirements of the law, and that improvements are required. The provider sent us an action plan detailing the improvements they would make. They have updated us regularly and informed us that the actions had been completed. In April 2015 we revisited the home and found

# Summary of findings

the compliance actions and warning notices had not been met. During the inspection we were concerned about the safety and welfare of many of the people we met and requested that the provider make urgent safeguarding referrals to the local authority for specific individuals we brought to their attention.

Heath House can provide nursing care and accommodation for up to 50 older people. People may also have additional needs including dementia and ongoing mental ill health. At the time of our inspection 37 people were living at the home. The home is split into two units, Walker and Heath. Walker unit provides care and support for older people with ongoing mental ill health and Heath unit is dedicated to the care and support of people living with dementia.

The home does have a registered manager. 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.

People living at Heath House could not be confident that the registered provider would be able to keep them safe. We saw staff supporting people to move using techniques which could cause them harm. People who were distressed did not always get the reassurance or support they needed.

Our observations showed there were not always enough staff in the right place at the right time to meet people's needs. We observed people being rushed, sometimes this caused pain and distress and on other occasions it caused people anxiety and denied people the opportunity to be independent.

People required help from the nursing staff to administer their prescribed medicines. We checked medicines storage, administration and the records. We did not find evidence that people had always been given the correct medicine, at the correct time in the correct dose.

New staff had not all been provided with an induction that would ensure they knew how to care for people living at Heath House and would ensure they could work safely. Staff had not all been provided with the training they required or with regular updates.

People's medical conditions were not always being treated appropriately by the use of their medicines. We found evidence that people had not received all of their medicines as prescribed.

Management staff at Heath House had identified some potential deprivations to people's liberty and had made applications to the supervisory body. However nursing and care staff we spoke with and the records we looked at in full did not show that people had benefitted from a full or accurate assessment of their needs.

People did not always have a pleasant meal time experience. We could not be certain that people always had enough to eat and drink.

People living at Heath House needed support from a wide range of health professionals. Some relatives told us people received good health care. However, we found examples where people's physical and mental well-being had not been well managed and people had experienced ill health as a result. Relatives also shared examples of people's personal care and healthcare being poorly maintained.

We observed some caring and compassionate practice, and staff we spoke with demonstrated a positive regard for the people they were supporting. We did not find that people had been consistently cared for in the way their needs required. We saw people who had not been supported to dress or to meet their personal care needs adequately to ensure they were clean and fresh. The number of staff on duty meant people often had to wait unduly long periods of time for the care they needed.

People were able to join in a range of activities provided at Heath House. Some people had been able to maintain interests that they had before moving to the home, and other people told us they liked the entertainers and exercise groups that visited the home. For much of our inspection we observed people sleeping and there were limited opportunities for people to engage or be stimulated.

There was a complaints process in place; however this was not always followed. This meant that people had not benefitted from an effective complaints process.

The management of the home had recently undergone significant change. At the time of our inspection there was no deputy manager in post and the registered

# Summary of findings

manager had been in post for five months. While we received positive feedback from people, staff, relatives and health professionals about the registered manager, it was not evident that the governance system (ways of checking the safety and quality of the service) in place in the home or operated by the registered provider had been effective. We were concerned that the registered provider had not provided resources and support to the home that were consistent with the number and severity of the issues identified during our inspection in December 2014.

We found the provider was in breach of Regulations. 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 not safe.

People who used the service were placed at risk because the provider did not have safe systems in place to manage their medicines or to reduce the risks associated with their care.

The provider had not made sure that people were supported by enough staff and this compromised their safety at times.

**Inadequate**

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

People could not be certain they would always receive good treatment for both their physical and mental well-being needs.

People could not be certain they would receive the support they required to eat a nutritious meal suited to their needs.

People could not be certain their rights in line with the Mental Capacity Act 2005 would be identified and upheld.

People who used the service were placed at risk because the provider had not recognised when their human rights would be compromised under the Mental Capacity Act 2005. People's right to healthcare was not always respected and this placed them at risk of inappropriate treatment.

**Inadequate**

**Is the service caring?**
The service was not caring.

Individual staff demonstrated kindness and compassion but the operation of the home did not ensure that people consistently received the care they needed.

The running of the service did not ensure care was always provided with dignity, or that people were as involved in their care as they wished or were able to be.

**Inadequate**

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

People were not getting individual care that met their needs.

The systems in place to listen and learn from people's experience were not effective.

**Requires improvement**

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

**Inadequate**

# Summary of findings

The culture at Heath House was not empowering or inclusive.

People did not benefit from a service that was well led. The lack of effective management placed people at risk of harm and unsafe treatment.

The systems in place to check on the quality and safety of the service were not effective, and had not ensured people were benefitting from a service that met their needs.

# Heath House

**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 inspection took place on 22, 23 and 29 April 2015 and was unannounced.

The inspection was undertaken by two inspectors, a pharmacy inspector, a special advisor who had knowledge about manual handling, and an expert by experience who had knowledge of supporting older people

We looked at the information we held about Heath House prior to the inspection. We looked at information received from relatives, from the local authority commissioner and the statutory notifications the provider had sent to us. A statutory notification is information about important events which the provider is required to send us by law.

During the inspection we spoke with ten people who lived at the home. Some people's needs meant they were unable to verbally tell us how they found living at Heath House, and we observed how staff supported people throughout the inspection. As part of our observations we used the Short Observational Tool for Inspection (SOFI). SOFI is a way of observing care to help us understand the needs of people who could not talk with us.

We spoke with two health care professionals, the relatives of seven people, the registered manager, representatives of the registered provider, and nine staff which included both registered nurses and care staff. We looked at parts of the care records for 12 people. We looked at the medicines management processes and records maintained by the home about staffing, training and monitoring the safety and quality of the service.

Inadequate

# Is the service safe?

## Our findings

We last inspected this service in December 2014. We found that people were not being kept safe and we assessed the provider as "inadequate" in this area. We used our enforcement powers and went back to check that the required improvements had been made. We found that the provider had not made the improvements required to keep people safe.

The provider was not protecting people from avoidable harm and abuse that may breach their human rights. We observed staff supporting people to move using techniques that were considered by professional bodies to be poor practice. Using these techniques can cause injury to the shoulders of the person being moved and to the staff supporting the person. We observed people being lifted in hoists. The slings used to lift people were often incorrectly positioned which could cause discomfort and damage to the skin of the person being moved. Staff had received training in how to move people safely, but we did not see that these techniques were always being used.

We observed staff use different techniques to support one person throughout the inspection. Staff we spoke with all had a different understanding of the person's support needs regards moving around the home. The support was not consistent with the person's care plan or risk assessment. We observed the person fall. A review of the person's records identified that previous falls had occurred that had not resulted in a review of the person's mobility support needs. The manager and nurses we spoke with were unable to explain why this area had not been reviewed. People did not consistently get safe or effective support to meet their mobility needs.

Four of the ten people we observed had bruises or wounds to their body. We looked in more detail at the needs of these four people. In all cases the wounds were unexplained and no investigation had been undertaken into the cause of the injury. Records had not always been completed documenting the wound; in some cases the records were incomplete. In no instances had there been any investigation into the cause of the injury. We asked the manager and nurses about the action they had taken and reviewed care records. People had not been reviewed by the Doctor. Actions had not always been taken by the home's nursing staff to ensure people were well after the injury was brought to their attention, and records to ensure that nursing staff on future shifts would be aware of the need and the care required had not been completed.

Providers are required to notify the Care Quality Commission about events and incidents that occur including serious injuries to people receiving care and any safeguarding matters. We call these notifications. Before our inspection we looked at the notifications that had been sent to us. These included some incidents where people had become unsettled and hurt another person living at the home. We spoke with staff about these incidents and looked for evidence to see how the events had been reviewed and what action had been taken to reduce the likelihood of a repeat incident taking place. There were no formal systems to measure the frequency or intensity of each person's behaviour, or any recording that would enable staff to identify potential triggers. We looked at people's care plans to see how these known risks had been assessed and what plans were in place to reduce the likelihood of someone being hurt again. The plans detailed the action that staff should take following an incident but they were not pro-active in suggesting ways or strategies that would keep people safe.

We looked at the plan in place to support one person who had caused harm to other people living at Heath House. On the first day of our inspection the person was on regular observations. Staff should have known where the person was and have completed records showing they had checked to ensure all was well. Staff we asked were not always aware where the person was or when the next observation was due. Records had not all been completed with the frequency agreed. This was not an effective way of supporting the person or keeping other people safe. Further incidents occurred. The person was then placed on individual supervision to ensure the safety of both themselves and other people living at the home. This action was not underpinned by any written risk assessment or guidelines for staff. Staff we spoke with all had a slightly different understanding of the purpose of the observations and their role. We observed the person being supervised even when in their own room by a member of staff sitting beside them. This did protect other people in the home but did not promote the person's freedom or choice and was

# Is the service safe?

unnecessarily intrusive and restrictive to the person. Failing to provide safe care and treatment is a breach of the Health and Social Care Act 2008(Regulated Activities) 2014. Regulation 12.

The registered provider had developed a tool for determining how many staff were required for each shift. This was based on the needs and dependency of the people living in the home. Our observations of staffing during the three days of inspection was that there were not enough staff in the right place at the right time to meet people's needs. Staff often rushed from one person to another and on occasion staff rushed people when moving them causing people to wince or cry out in pain. We observed periods of time when there were no staff in communal areas. Sometimes people were rude or abusive to each other without staff being able to provide support or distraction, sometimes people called out or banged tables or remote controls to attract attention. We heard people calling for help. One person shouted, "Hello" to attract the attention of a member of staff. A member of staff shouted "Hello" back to the person but no one came to support them. We heard one person repeatedly shout out, "For God's sake I need a drink." No-one came to them. One person repeatedly cried out, "There is no one here-no staff here." The person continued to get distressed and we observed them pushing themselves to standing from their chair. The person's risk assessment for falls identified them to be at high risk of falls and the management plan for this was to ensure they were supervised. One relative we spoke with described mixed experience regards staffing. They told us, "It is difficult to say if there are enough staff. Sometimes a few, sometimes plenty." Staff we spoke with also said there had been times when there were enough staff and other times not so. One member of staff told us," Sometimes we are short of staff. I would say to the point of being dangerous." Failing to provide staff in suitable numbers and with suitable skills and experience is a breach of the Health and Social Care Act 2008 (Regulated Activities) 2014. Regulation 18.

We looked in detail at ten medicine administration records and found that people's medical conditions were not always being treated appropriately by the use of their medicines. We found evidence that people had not received all of their medicines as prescribed.

When people needed their medicines administered by disguising them in food or drink the provider did not have all of the necessary safeguards in place to ensure that these medicines were administered safely. We were particularly concerned that the nursing staff were crushing modified release tablets when it clearly stated on the dispensing labels "Swallow this medicine whole. Do not crush or chew". This could decrease the effectiveness of the medicine and might not treat the person's condition as planned.

We looked at records for people who were having treatment patches applied to their bodies. The provider was unable to demonstrate that these patches were being applied safely in accordance with the manufacturer's instructions and this could have resulted in unnecessary side effects.

Medicines that needed storing in a fridge had not been well managed. One person whose insulin had been stored in this fridge had experienced instability in their diabetes which could have been caused by the insulin being administered being stored inappropriately.

The information available to the staff for the administration of, "When required medicines" was not robust enough to ensure that the medicines were given in a timely and consistent way by the nurses.

The management of medicines had been audited by the service. However the frequency and effectiveness of the audit process had been inadequate to identify discrepancies and ensure these were dealt with in an effective manner. We were unable to confirm that people's medicines were being safely managed and given as prescribed. This is a breach of the Health and Social Care Act 2008 (Regulated Activities) 2014 Regulation 12.

We found that there were systems in place to ensure that services and equipment provided at the home were well managed to keep people safe. We were concerned to observe that hoists were being stored in front of an emergency fire exit. This could delay the evacuation of the home in the event of a fire, and it was of concern that this was described to us as an established practice. Staff were unaware of where else the hoists could be stored, although senior staff were able to show us a designated store place.

We looked at the recruitment records of recently appointed staff and saw that all the required checks had been made before people were offered a position within the home. However the provider had failed to assess possible risks identified during the recruitment process, which could

Inadequate

# Is the service safe?

have placed people at risk from staff unsuitable to work in adult social care. Staff we spoke with confirmed that the necessary checks including references and a DBS check had been made.

Inadequate

# Is the service effective?

## Our findings

We last inspected this service in December 2014. We found that people were not receiving effective care and we assessed the provider as "inadequate" in this area. We used our enforcement powers and went back to check that the required improvements had been made. We found that the provider had not made the improvements required to ensure people received the support they needed.

We did not find that people were being supported to live their life in the way they chose or that people were experiencing the best possible health outcomes or quality of life. We spoke with two members of staff who had started work at Heath House within the past year. We asked them if they received regular supervision. Staff told us there had been some but these were irregular. We asked for records of supervision and there were no records to support that these had been offered or had taken place. Staff explained they had been offered shadow shifts with more experienced members of staff, however there was no formal record of any induction taking place, or any assessment of people to ensure they had the knowledge and skills to support people.

The organisation had a training plan for staff working at the home. We found that staff had been given on line computer based training about a range of topics that would help them work safely, but staff had not been given training or good practice guidance about the needs of people living with dementia, people who may communicate using challenging behaviour, or physical care needs such as how to reduce the risk of people getting sore skin, or how to care for someone at the end of their life. Lack of knowledge had contributed to the poor care we observed. We found that many staff had gained experience over their years working in care. Relatives we spoke with gave mixed feedback about the abilities of staff. Comments included, "I think they need more training" and "They seem to know what they are doing, they must get training." Our observations and discussions with staff did not provide evidence that staff had the underpinning knowledge required to require the specialist support and care people living at Heath House required. Failing to provide staff with the training, induction and support they need to undertake their work is a breach of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014. Regulation 18.

Our observations identified that some people were being deprived of their liberty and the manager was able to demonstrate that this had already been identified and that applications had been made to the local authority regarding these deprivations. However we spoke with seven staff about the Mental Capacity Act 2005 and the impact it had on their work. No staff were aware of any restrictions the service was currently imposing on people, and neither the nursing nor care staff we spoke with were able to describe how the act impacted on them or the care and support they provided. This would not ensure people's rights would be maintained or that people would get the support they required to maintain their safety and wellbeing. We looked at the records for two people concerning their ability to make decisions and their mental capacity. The documentation had not been fully completed for either person and did not provide clear information or guidance about the support each person required to decision make concerning significant issues they may face. During our inspection we occasionally observed staff seeking people's consent, however we also observed occasions when an entire process was completed without any discussion or involvement with the person. We observed staff at meal times supporting people with medicines, eating and drinking and during manual handling failing to communicate with or involve people. We observed staff do things for people instead of encouraging people to do things for themselves when we observed previously that people had the ability to do this. This did not encourage people to be active partners in their care. This was a breach of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014. Regulation 11.

People did not have free access to drinks or snacks and were reliant on staff to offer these to them. We saw that people had three meals each day and that a drinks trolley went round twice each day with a variety of drinks. In the afternoon people were also offered a cake. On the first day of our inspection we asked to be introduced to people who were being cared for in bed. We met three people who were in bed for reasons relating to their health. The people had not all received the support they required to stay clean. Significant amounts of food residue were still on people's face, night clothes and bedding. These people were unable to care for themselves and would have been reliant on staff to feed them and clean any spilt food during or after the meal. Two people we met had a visibly dry mouth, tongue and lips. There were no drinks in these people's rooms and

people were unable to help themselves or to call for staff to ask for a drink. Records we looked at showed these two people had sometimes gone up to 14 hours between drinks being provided. Records showed on occasions the person had been offered a drink at 5pm and then no further fluids until breakfast which was recorded on different days from 7.45am until 9.00am. These people had regularly not received adequate amounts of fluid to stay healthy and hydrated.

We found that improvements had occurred to the meal time experience for most people, although there were still significant improvements required. Some people were able to request the food they liked and we found that despite this they did not receive it. One person expressed their frustration that they rarely had boiled potatoes but always mashed. After bringing this to the provider's attention we observed on the final day of our inspection these had been provided. There were not always options available for people who followed a special diet related to their faith or culture or for people who chose not to eat meat. We observed on two out of three occasions people have only potatoes and vegetables as a vegetarian option was not available. People who spoke with us gave mixed feedback about the food. One person told us, "The food is very nice; fresh and well presented" other people expressed frustration about not being able to get food that they liked.

There was not always information about the choices available at meal times. There was no menu on display. We looked at the records of food eaten, and saw that people did not routinely have opportunity to eat five portions of fruit and vegetables each day. This is recognised by the Department of Health as an essential element to maintaining good nutrition.

We observed some examples of staff supporting people with kindness and patience, and showing skill in encouraging people who were reluctant to eat. We saw some staff come back to people later in the meal time. We also saw some poor practice where staff rushed people to eat or drink, we observed one person take a plate of food from another person. The plate of food was removed and neither person was given anything else to eat. We heard a person shouting that they were hungry. Staff told them they had eaten their breakfast and no further food or snacks were provided. We observed one person eating porridge with their fingers as they had dropped their spoon. Three staff walked this person and failed to offer them a clean spoon or support with eating. We observed a person start to feed themselves a meal. The staff took the spoon from them and started to feed them. When asked about this the staff told us this was "quicker and cleaner."

At the start of the meal cold drinks were provided at the table. These were topped up but there was no hot drink provided or offered at the end of the meal. Failing to provide people with a range of suitable, nutritious foods and drinks and failing to provide the support people need to eat is a breach of the Health and Social Care Act 2008. (Regulated Activities) 2014. Regulation 14.

People living at Heath House had a complex range of health needs, relating to both their physical, emotional and mental well-being. Care plans we reviewed recorded that it was the person's wish to be supported regularly with their personal care. There were no specific risk assessments or strategies to support staff to care for people who may be reluctant to attend to their personal care. People we spoke with were unable to tell us when they were last offered a bath or shower. We looked at records for three people. These all showed that people received a daily wash but no regular access to a bath or shower.

Staff described some people's needs to us, and the daily progress notes [records maintained by staff about the persons care and support needs] helped us to understand the needs people had. We found entries that showed people had experienced distressed behaviour, had unstable episodes relating to their diabetes, had unsettled nights and had not settled to sleep in their beds, and that people had been uninhibited in expressing their sexuality. We looked at people's care plans and risk assessments to see if these events had been recorded or used to contribute to a review of the person's care plan and risk assessment. This had not been the case. This meant that people may not have been getting care and treatment they needed or that referrals to relevant health services may not have been made when required.

The majority of people told us that they received good health care. We observed that some people were wearing glasses, hearing aids and dentures and people were unable to confirm when the relevant professionals had last visited them at home to check and maintain these. We observed one broken pair of glasses that had been placed on a high shelf. Staff told us they were unsure who these belonged to. We tracked the support that people with diabetes received to maintain good health. Professional guidance is that

Inadequate

# Is the service effective?

people should receive regular specialist eye and foot health checks, as well as regular reviews by a health professional of their blood glucose levels. There was no evidence that these had been requested or offered. We were not confident people always had the support they needed to maintain maximum independence or good health. Failing to provide people with the care they need to maintain their welfare and safety is a breach of the Health and Social Care Act 2008(Regulated Activities) Regulations 2014. Regulation 12.

Inadequate

# Is the service caring?

## Our findings

We last inspected this service in December 2014. We found that people were not receiving a caring service. We assessed the provider as "requiring improvement " in this area. We used our enforcement powers and went back to check that the required improvements had been made. We found that the provider had not made the improvements required.

We asked staff what they did to protect people's dignity and privacy and all the staff we spoke with were able to describe how they did this. While we experienced some of these practices in action we also observed staff working inappropriately. We heard staff using abbreviations of people's names without this being their expressed preference, we heard staff discussing people with their colleagues using derogatory language, and staff supervising people in communal areas of the home while yawning, talking amongst themselves and being disengaged from the people they were with. We had received concerns from relatives informing us their loved ones clothes had been lost, they had been observed wearing other people's clothes, and that on occasions people had been put into bed in the wrong rooms. One relative told us, "We label all the clothes, still they go missing. Brand new slippers and shoes have gone missing. Today he is wearing two different shoes. He couldn't do that. Staff have dressed him like that." The support given to people to maintain their appearance and basic good hygiene is also a breach of people's basic human rights. Failing to maintain the dignity and privacy of people using the service is a breach of the Health and Social Care Act 2008(Regulated Activities) Regulations 2014. Regulation 10.

People we met during the inspection had not all been supported to undertake personal care to a good standard and we observed people who were not clean and fresh. We observed people wearing dirty ill-fitting and damaged clothes, none of the men living at the home had been supported to shave regularly, people had not been supported to brush their hair, cut their nails or to wash their hands and face. We observed people walking around in socks and with bare feet. There was no evidence that this was the person's preference. Three relatives raised concern with us about the support their relative received with their personal care. They showed us that their relatives were unshaven, had long broken finger nails, one person had faeces on their hands and under their nails that we were informed was often there. One relative raised concern that if their loved ones finger nails were this long they were concerned for the person's toe nails. There were no records to support that chiropody appointments had been made or that staff had undertaken foot care. The person agreed to show us their feet and we observed their toe nails were long and sharp. One relative told us, "They don't dress him well. He always looks a rag bag. He has lost weight and we brought smaller clothes but they are left in the wardrobe." Another relative told us, "He always has long nails, unshaven and messy hair, it is unpleasant for him and for us if we take him out." Staff we spoke with told us it was not always possible to support people to the extent required due to the demands on staff and some people's reluctance to undertake personal care.

People told us that staff were kind to them. This was a view supported by relatives we spoke with who mainly described the staff in very positive terms. Their comments included, "I am very happy with the way they care for my mother", and "I think they [the staff] are all very kind." We heard some positive staff practices and saw and heard staff involving people in their care by offering them the chance to join in an activity, for choices at meal times or to move to a different room within the home. We spent the majority of our inspection observing the practice of staff and mostly heard staff speaking to people kindly. On several occasions we observed people becoming upset or anxious and when staff observed this they usually reassured the person and comforted them. There were times throughout our observations when people became distressed and no staff were in the area to observe this and to subsequently provide support. People in the lounges had no means of calling for help or support when this happened. This did not enable staff to respond to their needs or anxieties quickly. Staff actions had not been kind when they had failed to support people to meet their health needs or support them to be clean and fresh.

We looked at the care of three people in detail who had been assessed at risk of developing sore skin. All three people had been assessed as being at very high risk of developing sore skin. On all three days of our inspection we observed these people sit for long periods in the same chair. They had not been seated on a pressure reducing cushion and they had not been supported to change their position at regular intervals. One person we spoke with told

Inadequate

# Is the service caring?

us they had a sore bottom. Although these people had not developed sore skin the provider was not delivering care that was in line with their risk assessments, care plans or comments made by people.

The provider had failed to ensure that the home was operated and resourced in such a way that staff could routinely meet people's needs in the way they liked and required.

Requires improvement

# Is the service responsive?

## Our findings

We last inspected this service in December 2014. We assessed the provider as "requiring improvement" in this area. We used our enforcement powers and went back to check that the required improvements had been made. We found that the provider had not made the improvements required to keep people safe.

No formal complaints had been recorded since our last inspection. The registered manager brought to our attention the compliments book, where there had been some very positive comments made by visitors to the home about the care they had experienced or witnessed. However the book also contained a number of concerns about staff practice, the number of staff on duty and the lack of activities for people to participate in. It was of concern that these had not been recognised as a complaint and that no action had been taken to address the concerns and issues raised. One person we spoke with told us, "I raise matters but nothing ever seems to happen about it." They gave us some examples which we could not see had been recorded or actioned anywhere. Failing to have an effective system to identify, receive, handle and respond to complaints is a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Regulation 16.

We observed information about how to complain and raise concerns was on display around the home. Relatives we spoke with told us they had been given information about how to complain

Permanent staff that we spoke with were able to tell us about people's individual preferences and things that would make them happy. We found staff had obtained this knowledge from spending time with people and their relatives and this was not always recorded or reflected in the written care plans. We found that the shortage of staff and the need to balance permanent staff with agency staff members meant that members of staff were not always able to utilise their skills and experiences as they were not always working with the people they knew best. Staff we spoke with were able to describe ways of person centred working but expressed their frustration that they often had to sacrifice these to ensure all the basic jobs were done when they were short staffed.

One person told us that their faith was important to them, and confirmed that representatives from their church came to worship with them. Staff told us that individuals were able to maintain their faith and those ministers could be invited to the home if people requested this.

The home offered a range of activities and for some people this included maintaining interests that they had before they moved to the home. We were informed that the home had access to transport and could take people out although this had not occurred in recent weeks. People gave us mixed feedback about the activities available. Relatives we spoke with raised concern that there was little on a day to day basis for people to do. We observed that the home celebrated significant occasions, and on day one of our inspection a Saint Georges day party was held. We did observe some isolated activities for individual people, however for the majority of our inspection we observed people sleeping and we observed limited opportunities for people to engage or be stimulated.

We observed visitors being made welcome at the home throughout our inspection. We saw that relatives were enabled and supported to provide care where they wished or for example to help a person with their meal or drink. Visitors told us there were no strict visiting times and that they were made to feel welcome and were often offered a drink.

Inadequate

# Is the service well-led?

## Our findings

We last inspected this service in December 2014. We found that people were not benefitting from a well led service and we assessed the provider as "inadequate" in this area. We used our enforcement powers and went back to check that the required improvements had been made. We found that the provider had not made the improvements required to keep people safe.

We had previously inspected this home in December 2014, September 2014 and December 2013. Breaches of the Health and Social Care 2008 were identified at all visits. Despite an action plan being developed following each inspection the home failed to remedy these breaches and at each inspection further breaches were identified.

Our inspection did not find that the leadership, management and governance of the home had been effective. Because of this we had concerns for people's safety and we did not find that a good quality service was being provided. We observed some audits completed by the manager and staff working at the home. These had not all generated an action plan and it was not clear who was responsible for the work required identified by the audit. Despite being completed several months before or being completed repeatedly no changes to the areas audited had occurred. There were no effective systems to review people's safety. There had been no investigations into the contributing causes of any injuries, no staff had been held accountable for poor practice and no improvement plans to increase people's safety and decrease the likelihood of a repeat occurrence had been developed. The registered manager had submitted details to the registered provider of untoward incidents, accidents and clinical events. Although requested both at the inspection and after the inspection direct from the providers representative there was no evidence that these entries had resulted in any review of practice of the safety or quality of the service. No work to identify themes or trends and take necessary action to reduce the likelihood of a repeat incident had been taken. Failing to identify, assess and manage risks relating to people's health, welfare and safety is a repeated breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 13.

The home had undergone a change of management in December 2014 with a new home manager and deputy manager being recruited. Relatives, staff and people living at Heath House all told us they liked the new manager and shared with us examples of things she had supported them with or helped improve at the home Since our last inspection the deputy home manager had left the organisation and not been replaced. Clinical leadership and an effective deputy to ensure the smooth running of the home in the absence of the registered manager had not been provided. This had meant that safeguarding alerts and submitting notifications to CQC had been delayed as staff on duty were unable to complete these tasks. This was a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Regulation 17.

We were concerned that the governance arrangements put in place by the registered provider had failed to identify the number, complexity and severity of the issues we identified during this inspection. The checks and audits in place to monitor the safety and quality of the service were inadequate. We were informed that the registered provider had only undertaken one recorded audit of the service since our inspection in December 2014. The registered provider had not provided the required additional support, resources or monitoring to ensure the service which had been rated overall as "inadequate" improved. We asked to see evidence of the support provided to the registered manager. They informed us that they had not received any supervision, had received a very limited induction to the home and company and that despite requesting support from the provider to improve the home none was forth coming. The registered provider was also unable to provide us with evidence that this support had been given.

The home had two nurses on duty each shift who as well as providing clinical nursing care and support should lead and direct the care staff. Staff we spoke with told us that some delegation was undertaken each handover, but that the effectiveness of this varied according to the nurses on duty. During our inspection we saw some staff who lacked direction and some staff who were not working efficiently. In this way we could not be certain that staff fully understood their role or responsibilities. Communication systems to ensure that staff had the information they needed to provide good care and support were not effective. One staff member told us, "Communication is difficult, I feel detached, people don't tell you anything, you have to find it out. That takes a long time. We don't know what we've missed."

Inadequate

# Is the service well-led?

We were informed that no recent quality surveys had been completed. We observed that the home did have a suggestion box, but that this was on top of a high cupboard and would be inaccessible to the majority of people. We were informed that while the registered provider had no effective systems in place at the time of inspection there were plans in place to update the quality system, which would include locating a computer tablet at the home on which people could give real time feedback about their experiences.

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 10 HSCA (RA) Regulations 2014 Dignity and respect<br><br>People were not always treated with dignity and respect and people were not always given opportunities to be independent when this was commensurate with their abilities. |

**The enforcement action we took:**
**We are considering the action we will take in response to this breach of the Health and Social Care Act 2008 and will report on this when the action is complete.**

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 11 HSCA (RA) Regulations 2014 Need for consent<br><br>People's consent and agreement before receiving care was not always sought by staff. |

**The enforcement action we took:**
**We are considering the action we will take in response to this breach of the Health and Social Care Act 2008 and will report on this when the action is complete.**

| Regulated activity | Regulation |
|---|---|
| | Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment<br><br>The provider had failed to ensure that care and treatment provided was safely delivered. |

**The enforcement action we took:**
**We are considering the action we will take in response to this breach of the Health and Social Care Act 2008 and will report on this when the action is complete.**

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment |

This section is primarily information for the provider

# Enforcement actions

People were not protected from abuse and improper treatment, including neglect and acts of omission when treatment that had been identified as necessary had not been provided.

**The enforcement action we took:**
**We are considering the action we will take in response to this breach of the Health and Social Care Act 2008 and will report on this when the action is complete.**

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs<br><br>Nutrition and hydration needs of people were not consistently met, or met in people's best interests. |

**The enforcement action we took:**
**We are considering the action we will take in response to this breach of the Health and Social Care Act 2008 and will report on this when the action is complete.**

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints<br><br>The system to receive and manage complaints was no effective. |

**The enforcement action we took:**
**We are considering the action we will take in response to this breach of the Health and Social Care Act 2008 and will report on this when the action is complete.**

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA (RA) Regulations 2014 Good governance<br><br>Effective systems were not in place to ensure that the home was meeting the needs of the people, keeping them safe and managing risks. There was no evidence that the provider was seeking out feedback or evidence that people were consistently receiving the care, treatment and support they needed. . |

This section is primarily information for the provider

# Enforcement actions

**The enforcement action we took:**
**We are considering the action we will take in response to this breach of the Health and Social Care Act 2008 and will report on this when the action is complete.**

| Regulated activity | Regulation |
| --- | --- |
| Accommodation for persons who require nursing or personal care | Regulation 18 HSCA (RA) Regulations 2014 Staffing<br><br>Sufficient numbers of suitably, qualified, competent and skilled staff were not always available to meet people's needs. |

**The enforcement action we took:**
**We are considering the action we will take in response to this breach of the Health and Social Care Act 2008 and will report on this when the action is complete.**