Anchor Trust

Heather Vale

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection visit took place on 16 October 2018 and was unannounced. It was completed by two inspectors, a nurse specialist and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Heather Vale is a care home registered to support 39 people. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The accommodation is provided over two floors. On each floor there are two separate units. Each have their own dining facilities and assisted bathrooms. On the ground floor there is a large communal lounge and an accessible secure garden. At the time of our inspection 36 people were living at the home.

There was a registered manager at this location. 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.
At our last inspection we rated the service as 'Good.' At this inspection we found some areas required improvement

There were not always enough staff to support the needs of people. Risk assessments had not always been updated or reflected the persons current situation. When people received their medicine support this was completed safely. However, some areas of medicine needed improvement and plans were in place for the training to be completed.

When people were nearing the end of their lives, care plans and assessments did not reflect the support needs the person may wish. Some other care plans were not up to date in reflecting changes in people's care needs.

People were protected from the risk of infection and staff were observed to use gloves and aprons when supporting people with personal needs or support with their meal. Lessons had been learnt from events which had been used to make changes to drive improvements.

People were supported with activities to pass the day and regular entertainment or days out were planned. The staff worked in partnership with a range of professionals and local contacts. Meals provided people with a choice and supported their nutritional needs.

Complaints had been addressed and the registered manager understood their role in relation to their registration with us. Information was displayed for people and relatives to access, including the displaying of

the rating of the most recent inspection.

People are supported to have maximum choice and control of their lives and staff support them in the least restrictive way possible; the policies and systems in the service support this practice. Health care had a focus to ensure people's ongoing wellbeing.

Staff had received training to support their role. In addition, ongoing support was available to staff which they felt was responsive to their needs. Staff had received training in safeguarding and knew how to raise any concerns. When concerns had been raised they were investigated and addressed. The registered manager informed us of events and any actions they had taken.

We found two 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.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was not always Good.

There was not always enough staff to support the needs of people.
Risk assessments had not always been updated and did not always reflect the persons current situation.
Medicine was not consistently managed; however, areas had been identified for improvement.
People were protected from the risk of harm and lessons had been learnt to drive improvements.

Is the service effective?

Good

The service was Good

There was not always enough staff to support the needs of people.
Risk assessments had not always been updated and did not always reflect the persons current situation.
Medicine was not consistently managed; however, areas had been identified for improvement.
People were protected from the risk of harm and lessons had been learnt to drive improvements.

Is the service caring?

Good

The service was Good

People had developed positive relationships with the staff. Care was provided in a kind and compassionate way.
Relatives felt welcome and people's spiritual needs were supported.
People's dignity was observed and respect shown.

Is the service responsive?

Requires Improvement

The service was not always Good

When people were nearing the end of their life care plans were not always reflective of people's needs. Other care plans were

not always up to date to reflect current needs.
Opportunities were available to engage in activities and entertainment.
Complaints had been addressed in line with the policy.

Is the service well-led?

Requires Improvement

The service was not always Good

Due to areas identified at this inspection we could not be sure methods used identified improvements.
The registered manager had informed us of events or incidents which had occurred. The current rating was displayed at the home and on the website.
People's views were obtained and requests followed up.
Staff felt supported in their role.

Heather Vale

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.

The inspection was prompted in part by complaints and whistle blower concerns in relation to the staffing numbers and the care being provided at the home. We reviewed these in conjunction with other information we held about the service and the provider. This included notifications the provider had sent to us about significant events at the service. We reviewed the quality monitoring report that the local authority had sent to us. All this information was used to formulate our inspection plan.

The provider had completed a Provider Information Return as part of the Provider Information Collection. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.
Not everyone in the home could tell us about their experience of their life in the home, so we observed how the staff interacted with people in communal areas. However, we were able to speak with eight people and six relatives. We also spoke with four members of care staff, two team leaders, the deputy manager and the registered manager. We spoke with the district manager who was also present for the feedback at the end of our inspection.

We looked at the care records for seven people. We checked that the care they received matched the information in their records. We also looked at a range of information to consider how the home ensured the quality of the service was continuously reviewed, these included audits relating to accidents and incidents, infection control audits, complaints, compliments and surveys to reflect feedback. We also reviewed the records for recruitment to ensure staff employed by the provider had received the correct checks for their suitability to work with people. During the inspection we asked the district manager to share their monthly audit report, which was email on the same day.

Good

Is the service safe?

Our findings

There was not always enough staff to support people's needs. Prior to this inspection we received several calls raising concerns about the staffing levels. This was supported by the people and relatives we spoke with during the inspection. One relative said, "The staff are marvellous, but there just are not enough of them." Another said, "My relative had to wait a long time to go to the bathroom, which I do not find acceptable." Another relative said, "The number of staff is variable, sometimes there looks like a lot, but at other times it is really sparse."

Staff we spoke with raised concerns in relation to the levels of staff. One staff member said, "The people's needs have increased and the staffing has not reflected this." They added, "Some people need two staff and when we provide this support it leaves our section without a staff member." On the day of the inspection several staff had come into the home for a training session. Not all the training went ahead and this meant there was additional staff available above the planned numbers. This meant that we were unable to observe the usual levels of care being provided.

A Team Leader had come in for training and stayed to support the team of care staff. When we asked the staff what they were unable to do because of the current staffing levels they told us the biggest thing was spending quality time with people. We observed the staff were focused on the tasks required, for example regular turns for people or support in a routine way, there was limited opportunities for flexibility. One relative said, "Staff do their best to get around everyone for their needs, but if people require extra help or use their call bells then they struggle to meet this need." Another relative said, "It takes time for them to come and [name] then becomes agitated." They added, "We have waited regularly ten minutes, the longest time was twenty."

We saw the impact of the staffing numbers on the care being provided. For example, during the midday meal we observed one person sat with their meal in front of them for fifteen minutes before they were encouraged to eat. One family had commissioned their own care staff to provide care support at mealtimes as they were concerned their relative was not receiving this consistently.

Prior to lunch a staff member assisted one person to the bathroom. It was unclear how long the person had been sat in this location without the offer of support. This person required support to the bathroom and a complete change of clothes. This need was only observed when the person was approached to support them to move to the dining area. This meant we could not be sure the person's needs had been considered to reduce the possibility of this occurring.

The registered manager completed a dependency chart on a monthly basis to reflect people's needs and the possible level of support they required. This information influences the staffing levels. The provider told us last year they had increased the team leader positions in the afternoon from one to two, to support the staffing numbers.

We discussed the staffing levels with the district manager during our feedback. After the inspection they informed us they had increased the staffing levels during the morning and they would be reviewing this position through information and listening events. This meant that the provider had not recognised the need for additional staffing, without this inspection.

This demonstrates a breach in Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Risk assessments had not always been completed for some areas of identified risk. Some areas within the care plan had detailed the needs of the person and the action staff should take, however a specific risk assessment had not always been completed. For example, when supporting people to move. In addition, some risk areas had not been reviewed following a change in the person's care needs. For example, one person had changed the chair they were using due to the risk of sore skin. This had not been documented to provide the information to reflect the change in risk management.

When people required support to move with equipment, their care plans were not always up to date. We observed staff being unclear how to support one person and after some hesitation a piece of equipment was used. The risk assessment for this person had not identified the type of equipment to be used or how the support should be provided. This meant using equipment not assessed for could place the person and staff at risk of harm.

Relatives told us there was sometimes some inconsistency amongst the staff. They said, "You can talk to one staff member and you know it will be done, and then you can talk to another and you know it won't be done." We saw that not all the information in relation to changes had been cascaded. We discussed this with the registered manager and they agreed to review the approach in ensuring all changes were recorded in the care plans and discussed with staff.

Despite these concerns we identified, people they felt their safety had been considered and they were safe. One person said, "I feel completely well-cared for and indeed well-catered for here. Safety is not an issue." This person had been prescribed cream to reduce the risk of sore skin. To keep the cream safe, the person had been given a key to their room so they could lock it when not present. They said, "This is an example of the staff making sure things are safe."

The provider had recognised that some additional support was required around medicine management the registered manager said, "The audits had highlighted a number of medication errors and identified themes within these, which showed the need for extra training." We reviewed medicine as part of the inspection. Medicine administration records had been completed correctly and we saw that the stock to support peoples prescribed needs was well managed.

When people required medicine on an 'as required' basis (known as PRN), there was a protocol in place. One person had received a review of their PRN medicine as they were having it on a regular basis and requested for it to be added to their daily medicine needs. This showed a responsive and timely intervention to the changing pain management needs of the person.

However, some additional areas required improvement. For example, not all the bottles of medicine had a recorded date of opening. This is to reflect the start date which can be linked to the expiry period for some products. Without the recorded date we could not be sure the medicine was still within the accepted timeframe affecting the integrity and effectiveness of the medicine. We discussed this area with the registered manager and they confirmed this was an area identified in their own audits and was to be

covered by the additional training scheduled for October 2018.

In addition, we observed the storage temperature in the medicine room was over the agreed levels set out in the National Institute for Health and Care Excellence guidance. Fans had been placed in the room to reduce the temperature, however on occasions the temperature was still above the recommended level. The district manager had identified this in their monthly audit and an air conditioning unit was being sourced.

The provider and registered manager used a range of methods to reviewed the care being provided and to make improvements. The medicine example shows how analysing the audits and reviewing some medicine error had resulted in the need for additional training. The district manager had also held some listening events so that staff could share their ideas or raise any concerns directly. Following these events, a daily meeting called 'ten at ten' had been introduced. This was a brief meeting with all the head of the departments which meet to reflect on any daily issues. These included any changed to people's diets, any incidents or any events of significant which could impact on the care of people. This shows that lessons were learnt.

People felt safe from the risk of abuse. One person said, "I feel safe, staff have locked the front door so no one can get in, the staff take good care of us." Another agreed with this statement adding, "We are all locked in and we are safe.' The people and relatives we spoke with, felt that their loved ones were safe in the home. Staff had received training in safeguarding and were aware of the actions to take. We saw that safeguarding's had been reported to us and the local authority. Following these an investigation had been completed and any lessons shared with the staff.

Measure were in place to protect people from the risks associated with the control of infection. We saw staff used personal protective equipment, such as gloves and aprons when they provided personal care or served food. The home was clean and tidy and odour free. The home had a five star rating from the food standards agency, which is the highest award given. The food hygiene rating reflects the standards of food hygiene found by the local authority.

The necessary steps had been taken to ensure people were protected from staff that may not be fit and safe to support them. For example, before staff were employed, criminal record checks were undertaken through the Disclosure and Barring Service (DBS) . A DBS reviews police records to help prevent unsuitable people from working with vulnerable groups, including children. These checks are used to assist employers to make safer recruitment decisions.

Good

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides the 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. When they lack capacity to take particular decisions, any made on their behalf must be in their best interests and 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 Deprivation of Liberty Safeguards (DoLS).We checked whether the provider was working within the principles of the MCA, and whether any conditions are authorisations to deprive a person of their liberty were being met.

Assessments that had been completed to reflect people's consent to care. We saw best interest meetings had been instigated with professionals when a decision was required which could have an impact on a person's wellbeing. Staff had received some training in MCA and were able to explain to us how it affected the decisions people made. The registered manager told us that additional training was planned as they wanted to develop the assessment to reflect specific decisions. After the inspection the district manager shared with us the plans for the training and the timeframes. All the people who were subject to a DoLS had their application registered with the local authority, at the time of the inspection none of the DoLS had been authorised. ,

People's needs and choices had been assessed to reflect the support they may require for their specific condition. We saw one person had received a confirmed diagnosis and the details had been shared with the staff team. This meant staff could support people in relation to their health care condition.

Staff had received training to support their role. One staff member said, "The training is good and they make sure you are up to date." Another staff member talked to us about the training they had received in relation to dementia. They said, "It covers the different way people's mind respond to the illness and how you can approach people." New staff were supported through the training programme which reflected the care certificate. The Care Certificate is an agreed set of standards relating to care roles. We saw that training was monitored by the registered manager and followed up by the district manager in their monthly audit. Any staff who were required to complete training were supported.

People's dietary needs were supported. One person told us, "The food is smashing here." We observed the midday meal, people were given a choice of two options. One person told us, "If you don't want the choice they will always make something else." Tables were laid with cutlery and serviettes. Condiments and sauces were also available for the people if they wished to use them. People were encouraged to sit with friendships groups and social conversations were observed.

During the meal the deputy cook walked around the dining areas and talked with people about the meal. One person said, "I tell them when its good or not so good. Today the pie is delicious." We saw people's dietary needs had been catered for. This included changes made following an assessment from a health

care professional. A variety of refreshments were available throughout the day, in addition to a range of snacks. In each dining room there was a small kitchen which enable staff to provide drinks and snacks as requested.

In the PIR the registered manager told us each person had a diet summary sheet. We saw these were in place and have been shared with the kitchen. One person was lactose intolerant and we saw they received sauces and porridge to support this diet. Other diets had also been catered for. People's weights had been monitored and any concerns referred to health care professionals.

People were supported to live healthier lives and had access to healthcare services. One person told us, "Specsavers came to the home and tested my eyes and I have got me some new glasses." Another person said, "We have a hairdresser and a chiropodist and everything here." We spoke with three health care professionals who supported the home on a regular basis. All provided positive feedback about the care being provided to people in the home. Comments were, 'Staff are polite, good and efficient. Nothing is too much to ask,' and 'Everyone is genuinely kind people are cared for.'

Health care professionals told us that when the staff had any concerns they raised these with them in a timely way. We saw that guidance had been followed to reduce the risk of sore skin.
One person had been recommended to be turned on a two-hourly basis and to sit on a pressure relief cushion. The health care professionals told us, "Staff have followed this guidance and recorded the two hourly checks and the sore skin has started to heal." Another health care professional said, "I don't have any issues here, staff are friendly and always support us when we see people."

The home had been adapted to support people's needs. We saw that signage was in place to guide people around the home. Outside each room there were personal pictures and a name to identify each person's room. People had been encouraged to bring personal items from their home. The garden was accessible and had been designed with a pathway which guided you around the flower beds.

Good

Is the service caring?

Our findings

All the people and relatives we spoke with without exception felt that the staff were kind and considerate. One person said, "The staff are so nice, they know what we like and they help us so much." Relatives we spoke with also reflected this, one relative said, "Staff are fabulous, very caring and always smiling."

We observed some kind, genuine and meaningful interactions between the care staff throughout the day. Staff knew people well and when they provided care they took the time to speak with them picking up on visits and/or life events. For example, the birth of a grandchild.

People had been encouraged to be as independent as they were able or wished to be. One person said, "Staff know what I can do and they let me get on with it, but if I need help with anything they are always there." Another said, "Well they treat me as if I am a member of their family, which I suppose I am really, their 'care' family." This was a phrase used by several staff referring to people as part of their own family'.

People were supported to follow their spiritual beliefs. A local church provided a monthly service and members from the church also visit some people on an individual basis. The church visitor told us, "I visit people who would like to go to church, but can no longer do so." They told us, "The staff here are lovely and I can tell, how kind and caring they are." Staff were aware of the importance of recognising people's cultural or social needs as part of the support they may require.

Staff were observed to knock before entering a room and they asked the person's permission before entering their room or in relation to care being provided for example, supporting people to the bathroom.

Relatives were welcome to visit at a time suitable to their them. They were encouraged to use the kitchen to make refreshments whilst they were visiting their family members. One relative said, "We can always make whatever drinks we want in the kitchen, everybody can do that and it is free of charge. When we come to one of the cheese and wine events, which are quite frequent, we always donate." We observed relatives accessing the kitchen and the available refreshments.

Requires Improvement

Is the service responsive?

Our findings

When people were nearing the end of their life a reassessment had not been completed. At the time of our inspection three people had been recognised by health care professionals as being end of life (EOL). However, their care plans did not reflect this. The district manager told us the organisation had a specific care plan when people were EOL, but this had not been put into place. By not completing this assessment we could not be sure the people's cultural, religious or social needs had been taken into consideration.

The health care professionals told us that all three people had been prescribed anticipatory medicines for when these would be needed. These medicines relieve the distress and support pain management for people in their last hours or days. However, there was no documented plan of how the persons pain relief would be managed. By not having these details in the care plan staff are not fully supported to provide the care in a way the person would wish. The district manager agreed to review this area of the care for these people and assured us information would be cascaded to the necessary staff.

People's care plans did not always reflect personalised care, so that care would be responsive to their needs. Some care plans we reviewed were more detailed than others, however overall, they did not contain the information the care staff needed to provide individualised safe and effective care. For example, two people who had different types of dementia did not contain any information on their diagnosis, condition or how the person could or would present themselves. This information would support staff on how best to interact with them. We saw some information had been recorded in the Life Story documentation, however this had not always been used to develop the care plans.

Team Leaders were currently providing care which meant they were unable to carry out some aspects of their role for example, care planning and spending quality time with the residents. We reviewed the district managers monthly audit, this noted, 'Time management is an issue, team leaders are struggling to complete allocated tasks and duties. Care plans are now due to be rewritten and reviews are behind.'

Relatives we spoke with had mixed views on the review process. One relative said, "We have a review once a month with the staff and talk about [name] care needs." They told us, "Name] is reluctant with their personal hygiene so we are working together to try and address this." However, other relatives felt that when reviews had been held the information was not always communicated. One relative said, "We are involved in a review each month, they listen at that point, but then information is not always passed on." We saw that the reviews were written on a different form and not clearly linked to the care plan, making it difficult to know if a care plan was still in date.

This demonstrates a breach in Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff used a range of methods when communicating with people. These were in ways which the person could understand. For example, some people responded to visual prompts and/or hand gestures. For one person the staff used picture cards. One staff members said, "The person is able to point to pictures." One

person was hearing impaired and had a loop system in place to assist them to hear their television. This person also had a vibrating alarm pillow, this was so they would be alerted in the night if the fire bell was activated. This shows the provider was adhering to the Accessible Information Standard (AIS). This was introduced to make sure that people with a disability or sensory loss are given information in a way they can understand.

People were supported to enjoy a range of activities to support their own interests or to discover new experiences. There was an activities coordinator employed in the home, people we spoke with talked about the variety of activities available. There were posters displaying the planned activities and up and coming trips out. These included, ponies in the home, visits from children and a 60's singer. We saw in the care records that some people had received someone to one time and had been able to go out to the shop or have coffee and cake in the local town.

The activities person had engaged with art departments of local schools and colleges help create murals on the walls within the home. One had already been created which was interactive. People could move some of the figures on the wall to different areas. Annual occasions were celebrated, the home was decorated for Halloween and plans had been made for Christmas. These included a planned pantomime for the residents and their families, a carol service with children from the local schools and the Salvation Army. The staff member told us, "One of the people used to belong to the Salvation Army so this is very special day for them." The activity co-ordinator has also made a fund-raising link with the local supermarket.

On the day of the inspection, there was a meeting for the people and relatives. One of the main focuses of the meeting was to discuss the future of the activities. The plan was for the activities specific role to be removed and that activities would be dispersed among the care staff on a daily basis. All the staff were to receive training in how to complete activities and embed them into the daily routine. There was also the discussed about a programme called, 'Our Yesterday' which would information about what happened on a certain day in a certain year in the past, to be used to encourage discussions and reminiscence.

The complaints procedure was on display in the reception and people and relatives we spoke with felt confident in raising any concern. One person told us how they had raised a concern and this had been dealt with swiftly. Written complaints had been responded to and addressed in line with the policy. Although not formal complaints three people families had raised concerns in gaining access into the home.

Relatives spoke of long delays standing outside the door before it was answered. One relative had recorded the length of time they had waited. They said, "The most I have had to wait is 18 minutes and then I phoned them to say I was at the door." Another relative relayed how they had taken their relative out, when they returned they waited some time, when the door was eventually answered the staff member said, 'You look frozen.' We discussed this with the district manager and they raised concerns about confidentially and privacy. However, they did agree to review the doorbell to ensure it could be heard around the building and consider other options to enable easier access.

Requires Improvement

Is the service well-led?

Our findings

We saw that the provider had completed many audits to reflect on the quality of the home. However, they had not taken action to address the staffing concerns which had impacted on the support people required. Complaints had been received from several relatives in relation to access into the home. Staff were not always able to answer the door in a timely way and this was also a factor in recognising the staffing levels. It had been identified that the care plans, were not being kept up to date and action had not been taken to address this area.

We reviewed the range of audits which are completed on a monthly basis. These were then shared with the district manager and the provider. Any areas of concern identified resulted in an action plan in how it would be addressed and then once completed signed off by the district manager. We saw the medicine audits had resulted in additional training being implemented. The home audit had identified the carpet needed replacing and we saw this was planned to be done shortly. Other environmental elements had been reviewed and within the lounge area the temporary bar area was to be made permanent. Staff commented that these things were positives and helped increase the wellness element for the people.

Heather Vale had 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.

The people told us they enjoyed the atmosphere of the home. One person said, "I feel totally relaxed living here." Relatives also complemented the home on its 'homely' atmosphere and the welcome they received when they visited.

Staff felt supported by the registered manager and deputy. One staff member said, "They are approachable, you can pop in the office any time." Staff told us they received supervision to guide them in their role. One staff member said, "We cover all aspects of training and any support I might need."

People had been encouraged to be engaged in the developments of the home. There were people who used the service and relative meetings. Social events had also occurred to provide a relaxed atmosphere for information to be exchanged, for example, cheese and wine events. There was a 'you said we did' board on display in reception which reflected a recent request for a named key staff member, which had been implemented. We saw that other feedback reflected to purchase 'comfort toys' and these had been purchased.

The provider worked in partnership with health and social care professionals to ensure people's wellbeing and health care was supported. In addition, links had been made with local school and the church.

The manager ensured that we received notifications of important events in line with their registration. This meant that we could review that appropriate action was taken. We also ask the provider to display their

latest CQC inspection report at the home and on their website. This is so that people, visitors and those seeking information about the service can be informed of our judgments. We found the provider had displayed their rating as required.

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 People did not always received personalised care which was based on their preferences.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There was not sufficient numbers of staff deployed to met people's needs.