Quantum Care Limited

Heath House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 09 November 2015 and was unannounced. When we last inspected the service on 27 September 2013 we found the service was meeting the required standards at that time.

Heath House provides accommodation for up to 62 people with residential and dementia needs. It does not provide nursing care. At the time of this inspection there were 58 people accommodated at Heath House.

There was a manager in post who had submitted an application to register with the Care Quality Commission (CQC). A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At the time of the inspection we found that applications had been made to the local authority where people's freedom was restricted and they were pending an outcome.

People and their relatives told us that they felt people were safe living at Heath House. Staff and management were knowledgeable about safeguarding matters. Risks to people`s mobility and general safety were identified and risk assessments had been developed to mitigate these risks. Our observations during the inspection confirmed that staffing levels in the home were appropriate to meet people's needs. Staff members did not start to work at the home until satisfactory employment checks had been completed. There were suitable arrangements for the safe storage and disposal of people's medicines.

People were supported to make meaningful meal choices and people were assisted to eat in a calm and unhurried manner. People received care and support from a staff team who were well supervised and had the knowledge and skills necessary to provide safe and effective care. Staff asked people for their consent before they delivered all aspects of care. People's health needs were well catered for.

People were complimentary about the care and kindness demonstrated by the staff team. Staff were knowledgeable about individual's needs and preferences and people were involved in the planning of their care where they were able. Visitors were encouraged at any time of the day and people's privacy was promoted. We observed sensitive and kind interactions between staff and people who used the service.

Care was centred on the needs of individuals. There were arrangements for activities and stimulation in the home that were under development at this time to increase the opportunities for people to become further engaged. Meetings were arranged with people who used the service, and their relatives to facilitate feedback about the quality of the service provision. People were confident to raise anything that concerned them with staff or management and satisfied that they would be listened to.

People who used the service, their relatives and staff members found the home manager to be

approachable and supportive. Systems in place to monitor various aspects of the care delivery in the home were not always effective in identifying areas of poor practice.

Assessments had not always been accurately completed with correct information in order to identify the level of support people needed and to provide staff with the relevant guidance. The provider's audits had not identified these shortfalls in record keeping.

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 safe.

People were supported by staff who knew how to recognise and report abuse.

Individual risks were assessed and reviewed.

People were supported by staff who had been safely recruited.

People's medicines were managed safely.

Is the service effective?

Requires Improvement

The service was not always effective.

People at risk of poor nutrition did not always receive the support they needed.

Staff sought people's consent before providing all aspects of care and support.

People received support from staff who were appropriately trained and supported to perform their roles.

People had access to health and social care professionals as needed

Is the service caring?

Good

The service was caring.

People were treated with warmth, kindness and respect.

Staff had a good understanding of people's needs and wishes and responded accordingly.

People's dignity and privacy was promoted.

Is the service responsive?

Good

The service was responsive.

People were supported to engage in a range of activities.

People's concerns were taken seriously.

Is the service well-led?

Requires Improvement

The service was not always well led.

Records were not always accurately maintained.

People had confidence in staff and the management team.

The provider had arrangements in place to monitor, identify and manage the quality of the service. However, internal audits did not always identify areas of shortfall.

The atmosphere at the service was open and inclusive.

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 met 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 under the Care Act 2014.

This inspection took place on 09 November 2015 and was unannounced. The inspection was carried out by two inspectors 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 service.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed information we held about the service including statutory notifications that had been submitted. Statutory notifications include information about important events which the provider is required to send us.

During the inspection we observed staff support people who used the service, we spoke with ten people who used the service, six relatives, eight care staff members, the chef manager, the home manager and a representative of the provider.

We received feedback from a healthcare professional involved with the support of people who used the service and from a representative of the local authority social working team. We also 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 reviewed care records relating to eight people who used the service and other documents central to people's health and well-being. These included staff training records, medication records and quality audits.

Good

Is the service safe?

Our findings

People told us that they felt safe living at Heath House, one person said, "Yes, because of carers. There's always someone around." Another person told us, ""Yes, because staff are excellent, cannot fault it."

Relatives told us that Heath House was a safe environment for people. One person said, "I visit every day and [relative] is looked after well." Another relative said, "Pleased with it. Much safer here than at home."

All the staff we spoke with were confidently able to describe what constituted abuse and said that they would escalate any concerns they had. Staff members told us that they had received training to support them to understand the different types of abuse that could occur and they had been given a list of contacts, both within the organisation and of external organisations, to whom they could report any safeguarding concerns. This showed us that the provider had taken reasonable steps to identify the possibility of abuse and prevent it before it occurred.

Risks to people`s mobility and general safety were identified and risk assessments had been developed detailing the measures to be employed to mitigate these risks. For example we saw that a person had been assessed as being at a high risk of falls when mobilising independently. Staff carried out preventative measures to manage the risks to the person including checking that the person had their walking aid at hand and also their call bell. People who had been assessed as requiring bedrails on their bed to prevent them falling had protective covers over the rails to reduce the risk of entrapment.

We received mixed feedback from people who used the service about the staffing levels in the home. Some people told us they thought there should be more staff as they always seemed to be rushed whereas others said there were enough staff available to care for them safely. Relatives said that staff were sometimes 'stretched' but that there was always a staff member available when needed. Our observations during the inspection confirmed that staffing levels in the home were appropriate to meet people's needs, the home was calm, and people had their needs met in an unrushed manner.

Staff told us that the staffing levels at the home were consistent and they seldom had any issues regarding staffing. One staff member had become unwell during the course of the morning and had to leave the service however; assistance was provided for the unit at peak times by other members of staff. For example, during lunchtime an additional member of staff helped to ensure people had the assistance they needed to eat their meals. The manager gave us an example of where people's needs were the driver for staffing levels in the home. A person who used the service had experienced reduced mobility as a result of an operation so the manager ensured that staffing levels were increased to make sure that there were sufficient staff available to meet people's needs. This showed us that staffing levels were determined by the level of people's needs.

We reviewed recruitment records for two staff members and found that safe and effective recruitment practices were followed to ensure that staff did not start work until satisfactory employment checks had been completed. Staff we spoke with confirmed that they had to wait until the manager had received a

copy of their criminal record check before they were able to start work at the home. This helped to ensure that staff members employed to support people were fit to do so.

There were suitable arrangements for the safe storage and disposal of people's medicines. Staff told us that they had received medicines training before they were allowed to administer medicines on their own and records confirmed this. There was limited information in people's medicine administration record (MAR) folder to advise staff about what the medicines were for or what the common side effects were and we found there were no care plans or protocols in place to guide staff on how and when to give medicines prescribed 'as required'. We discussed this with the manager who acknowledged the shortfall and advised that this had been identified and was work in progress at this time.

We observed staff members encouraging people with their medicines, going at their pace and without rushing them. Each person had a medicine administration record (MAR) in their name with associated photograph to ensure staff could identify that person correctly prior to administering their medicines. This helped to ensure that people received their medicines safely.

Safety was discussed during meetings held with people who used the service. Minutes of the meetings showed that people confirmed they felt safe living at the home and they recognised the fire alarm bell as being an emergency bell.

Requires Improvement

Is the service effective?

Our findings

People who used the service, their relatives and the staff team all told us that staff had the right training and skills to provide them with safe care.

People were supported by a staff team who had the knowledge and skills necessary to provide safe and effective care. Staff told us that they were provided with regular training and that they were also offered opportunities for more advanced training to develop their careers. One member of staff told us, "Everyone's very professional here because they've had the right training." We noted that the manager had undertaken a review of staff training requirements since coming into post in August 2015 and they had identified the training needs and had made arrangements for staff to attend.

New staff members were required to complete an induction programme and were not permitted to work unsupervised until they had been assessed as competent in practice. A recently recruited staff member told us that even though they had done previous care work they had been given a three day classroom based induction followed by two weeks shadowing a more experienced member of staff.

Staff told us that they received regular supervision from a line manager and said they were able to discuss any aspect of their role with seniors which made them feel supported and valued. They told us that the management team was very supportive. Prior to the current manager coming into post there had been a period of instability in the management of the home which had resulted in some staff members not receiving their supervision. However, the manager had reviewed this area and had developed a tracking system to be able to monitor the frequency of supervision for the whole staff team going forward.

The Mental Capacity Act (2005) provides a legal framework for making particular decisions on behalf of people who may lack 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. Where they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests 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 in line with the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

Staff asked people for their consent before they delivered all aspects of care. A member of staff told us that people were happy because their personal choices were central to the ethos of the home. They said that this was why people exhibited very little distress or behaviours that could be challenging to others.

Documentation in people's care plans showed that decisions had been made in their best interests when they lacked capacity due to their dementia. People and their relatives, where appropriate, had been consulted about decisions on their care and treatment at the end of their lives.

The manager demonstrated a good understanding of when it was necessary to apply for authority to deprive somebody of their liberty in order to keep them safe. They had an awareness of what steps were needed to be followed to protect people's best interests and how to ensure that any restrictions placed on a person's liberty was lawful. At the time of the inspection we found that applications had been made to the local authority in relation to people who lived at Heath House and were pending an outcome.

People shared mixed views with us about the food provided at Heath House, some people said they really liked it and others were less complimentary. One person told us, "Can't fault it. Plenty. Well cooked." Another person said, "Could be improved a bit. They do ask for suggestions but don't always do them." Relatives who often visited to support their relative to eat their meals told us that they thought the food was fine.

We observed people's dining experiences in all four units of the home. Dining tables were nicely laid and the environment was clean and welcoming. People sat in small groups and in some units we noted that sociable interaction took place in the dining room. People were offered a choice of meals at the point of service and people who struggled to make a choice were shown the two options for them to make a meaningful choice based on the smell and appearance of the food. People who needed assistance received this from staff seated next to them in a calm and unhurried manner.

Where possible people had their weight regularly monitored to identify any risks of malnutrition. If a person had significant unplanned weight loss staff contacted the GP and dietician for advice and dietary supplements were then prescribed if necessary. However, we saw an example where a relative had requested that a person was not weighed because it caused them pain and discomfort. We found that staff did not use a screening tool to estimate the person's weight and they told us there were no management guidelines available to support them to assess the adequacy of people's diet in maintaining their weight and preventing them from the risk of developing pressure sores. In addition people's weight was required in order to adjust the pressure relieving mattress to their specific needs.

In order to assess the risks of people developing pressure sores and the risks of malnutrition it is necessary to have accurate records relating to people's weight and height. We found examples where records for people's height, weight and body mass index were inconsistent. For example, one person was recorded as having lost over 10kg in a month but regained the weight the following month. The height for another person was recorded in one place as 4ft 6in and 1.6m (5ft 2in) in another.

People told us that their health needs were well catered for. We saw that chiropodists, dentists and opticians visited the home when people needed them and people had easy access to their GP. Relatives told us that they were satisfied with the health care people received. We noted that referrals had been made to external health care agencies such as a mental health consultant and a district nurse.

Good

Is the service caring?

Our findings

People were very complimentary about the care they received and said that staff members were kind and caring. A relative told us, "It's a home from home, it's not impersonal, it's a very relaxed place. The staff are lovely, it's a terrific home." A visiting health professional told us, "It's a brilliant home. If I had dementia I would be happy to come here."

Staff were friendly, respectful and caring throughout the home. Staff told us that they were happy working at Heath House and felt that this resulted in a happy atmosphere for people living in the home. One member of staff told us, "We're like a family here." Another said, "It's a happy place because the home is run according to their personal choices. Staff understand people's different ways of communicating so they don't get so frustrated."

Staff were knowledgeable about people`s individual needs and preferences in relation to their care and we saw that people had been involved in discussions about their care. Staff gave people enough time to respond and then acted upon the choices that people had made. Throughout the course of the inspection we heard staff provide people with choices about what they wanted to eat and drink and where they wished to sit in the communal areas.

Where people lacked the capacity to contribute to their plan of care we saw that family members had been involved. We noted that a document called, "all about me" had been incorporated in the development of care plans and contained details of individuals' needs, preferences, likes, dislikes and interests. We noted that there was a lack of advice and guidance available for people about advocacy services. We discussed this with the manager who acknowledged this and undertook to ensure this information was made available to people.

Relatives and friends of people who used the service were encouraged to visit at any time and on any day.

We saw staff knock on doors and allow people time to respond before they entered. When people required support to use the toilet or personal care needs, they were supported discreetly to ensure they received support in private and with their dignity intact. People's care records were stored in a lockable office in each of the four houses in order to maintain the dignity and confidentiality of people who used the service.

Good

Is the service responsive?

Our findings

People and their relatives told us that they had been involved with developing their care plans to meet their individual needs. Relatives told us that staff contacted them whenever there was any concern about people's health needs.

Care was centred on the needs of individuals. Staff responded to people's non-verbal signs as well as to their requests for assistance and staff knew people well.

People's care plans showed that their views were sought in creating care plans to reflect their individual preferences and needs. For example, one care plan we reviewed stated that the person liked to wear colourful clothing, enjoyed wearing jewellery, preferred their hair to be well groomed and sometimes liked to wear lipstick. When we met the person we noted that they had been supported with their personal care in accordance with their care plan. Where people did not have the capacity to be involved in developing their own care plans we noted that their relatives had been involved.

The standard of care plans and risk assessments was variable throughout the home. The manager was aware of this and had made arrangements to review all care plans. Some care plans painted an extremely good picture of the person behind the dementia. They gave detail of people's varying abilities, their preferences and their means of communicating these preferences. They also provided information on people's care needs and how staff could help them to maintain their abilities for as long as possible. Some of the life histories within care plans were detailed so that staff had an understanding of people's background and interests, even if people now had limited communication. This enabled them to respond and treat people as an individual.

We noted that care plans for people's health needs such as diabetes care, pain management, and Parkinson's care lacked detail. For example, a care plan to manage a person's diabetes did not cover the risk of complications and the signs and symptoms of a low or high blood sugar. The care plan for one person who had a very variable appetite mentioned their risk of choking and the need for a pureed diet. However, there was no mention of the need to ensure that they ate an adequate diet to maintain their weight. This meant that staff may not always have access to the specific guidance they needed to provide people's care safely. When we spoke with staff they were able to tell us the care and support they provided but they acknowledged that the care plans did not support them in this area.

Most people told us that there were enough activities going on at the home. Some told us that they joined in and some said that they preferred not to. People told us that their views and preferences were taken into account and listened to. One person told us, "I asked if we could have more activities and now there's more. I like making things like basket weaving." Another person said, "They take us out for a meal sometimes."

There was regular outside entertainment brought into the home such as singers and pat dogs. We noted that the in house activities provided were generic in nature. For example, group exercise sessions, sing-alongs, quizzes, coffee mornings, word games and a Sunday service. On the day of the inspection we saw a

number of people doing large piece jigsaws together. The manager told us of an example where a person had told them of their love of horses and how they were sad that they didn't have the opportunity to be around horses anymore. In response to this the manager arranged an outing to local stables and we saw a picture of the person happily engaging with a horse. This example was given by the manager to demonstrate the outcome that he was working towards for all people who used the service.

On one unit in the home staff were sitting and chatting with people in the period immediately before lunch, there was much laughter and friendly banter. However, on another unit we saw that staff were busy with tasks such as bed making and washing up from breakfast and did not have the opportunity to spend this quality time with people. The manager reported that this day was unusual in that a staff member had suddenly taken sick leave and a member of the management team was on annual leave which meant there were not as many staff resources available as there would be under normal circumstances. Staff we spoke with confirmed this.

The manager had arrangements in place to support people and their relatives to share their views and talk about any improvements they would like. We saw that these views were taken into account and acted upon. For example records of a meeting held for the people living in Highgrove unit showed us that six people had attended and they had discussed such matters as safety, the food, the activities provision and staff matters. Some people had said that they wanted to be involved in the plans for entertainment for Halloween; we saw that the activities co-ordinator had been asked to liaise with people.

People and their relatives told us they would be confident to raise anything that concerned them with staff or management. A person who used the service told us, "I complained about going to bed at 8:30pm. They agreed I could stay up later." We reviewed records of complaints recently received and noted that they had been dealt with in accordance with the providers policies and procedures for managing complaints.

We saw feedback from relatives of people who had used the service and from people who had stayed at Heath House for periods of respite care that was positive with glowing compliments for the kind and caring staff team.

Requires Improvement

Is the service well-led?

Our findings

The manager had systems in place to audit various aspects of the care delivery in the home. These included areas such as medicines, care planning and delivery, health and safety, the environment, accidents and incidents, complaints, infection control and mealtimes. Information about the outcomes of these checks, together with any areas for improvement identified, was reported to the provider each month with details of actions taken and progress made.

However, we found that these audits were not always effective. In order to assess the risks of people developing pressure sores and the risks of malnutrition it is necessary to have accurate records relating to people's weight and height. We found examples where records for people's height, weight and body mass index were inconsistent. For example, one person was recorded as having lost over 10kg in a month but regained the weight the following month. The height for another person was recorded in one place as 4ft 6in and 1.6m (5ft 2in) in another. This meant that people's BMI was incorrect and that they may not have always received the appropriate support with their nutritional needs.

Records were not always accurately completed to reflect what additional food and fluids had been offered and encouraged if people only ate part of their meals or refused them. For example, a person was prescribed a supplement twice a day but staff could only evidence that they were receiving it once a day. The chef manager reported that high calorie drinks were supplied by the kitchen to supplement people's diets however; we were not able to confirm this through speaking with staff or by reviewing records.

Risk assessments undertaken to identify the risks to people of developing pressure sores were not always accurate because no score had been given for the fact that people had varying degrees of dementia. We noted that this was the case even if people were at the later stages of their dementia with less ability to assess external pressure or to move their position independently on a regular basis.

Care plans for specific health needs such as diabetes care, pain management, and Parkinson's care lacked detail. For example, a care plan to manage a person's diabetes did not cover the risk of complications and the signs and symptoms of a low or high blood sugar. The care plan for a person who had a very variable appetite mentioned their risk of choking and the need for a pureed diet. However, there was no mention of the need to ensure that they ate an adequate diet to maintain their weight. This meant that staff may not always have access to the specific guidance they needed to provide people's care safely

The provider did not maintain accurate, complete and detailed records in respect of each person who used the service. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People who used the service, their relatives and staff members told us they thought that the home was well-led. They told us that the home manager was approachable, supportive and demonstrated strong, visible leadership. One person said "A very nice man. Most days comes round and asks how you are." Another

person said, "I have met the manager. He goes round sometimes. Quite friendly." A relative told us, "Nice guy, passionate about what he does. Keeps an eye on [relative]." Staff told us that the felt the manager was approachable and supportive.

The manager had started in their role at the home in August 2015. Their application to register with CQC had been submitted in a timely manner and was in the process of being approved at the time of this inspection.

The provider organisation had developed a project called 'Rhythm of Life' which had been designed to look at every aspect of care delivery, both from a staff view and from the view of people who use the service. The aim was to provide a safe and homely family atmosphere where care staff focused on people's strengths to help maintain their natural Rhythm of Life. The project included areas such as staff recruitment and development, care planning and assessments. We saw the report of a visit by a representative of the provider to review the progress and outcome of the project. We noted that they had undertaken a comprehensive assessment of many aspects of people's day to day life at the home and that actions for improvement had been identified with dates for completion. For example, the audit identified that staffing levels needed to be monitored on one unit to ensure they were suitable to meet people's needs and discussions held with people about their personal wishes and preferences relating to activity and stimulation needed to be recorded. An action plan had been developed to address all identified areas with a date for completion and a named person to be responsible for ensuring the actions were taken.

We saw a report of a quality monitoring visit undertaken in February 2015 by representatives from the local authority Adult Care Services. The service had achieved an overall score of 86.2% with no areas of serious concern identified.

The manager facilitated meetings held with people who used the service and their relatives and survey questionnaires were distributed to people who used the service, their relatives, external stakeholders and staff. The manager also told us that they operated an 'open door' policy and frequently met with family members to explore any concerns or compliments they had about the service provision.

The manager had developed links with professional support organisations to access additional training, development and improvement opportunities for both staff and the service as a whole. The manager networked with other homes and home managers to explore areas of good practice to introduce into Heath House. For example, they had undertaken a recent visit to a service to explore sensory equipment used by people who lived with dementia with a view to introducing this at Heath House.

Providers of health and social care are required to inform the Care Quality Commission, (CQC), of certain events that happen in or affect the service. The manager had informed the CQC of significant events in a timely way which meant we could check that appropriate action had been taken.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not maintain accurate, complete and detailed records in respect of each person who used the service. Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.