Abbey Healthcare (Kendal) Limited

Heron Hill Care Home

Inspection report

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Date of inspection visit: 11 May 2015
Date of publication: 14/07/2015

Ratings

Overall rating for this service	Requires improvement
Is the service safe?	**Requires improvement**

Overall summary

We carried out an unannounced comprehensive inspection of this service on 21and 22 October 2015 at which breaches of legal requirements were found that had an impact on people living in the home. This was because the registered provider had not always made sure there was the right mixture of staff skills and experience on all shifts or that training and staff support was monitored so people could be sure staff had the right skills and experience to support them.

Following the comprehensive inspection , 21and 22 October, the provider wrote to us to say what they would do to meet legal requirements in relation to the breaches. They sent us an action plan setting out what they would do to improve the service and meet the requirements in relation to the breaches and when this would be completed

After that inspection, 21and 22 October, we received concerns from other agencies and individuals in relation to the levels of suitably qualified staff being deployed in the home to meet people's needs and to provide individual support where it was needed. As a result we undertook a focused inspection on 11 May 2015 to look into those concerns. This report only covers our findings in relation to this topic. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Heron Hill Care Home on our website at www.cqc.org.uk

Heron Hill Care Home provides accommodation and nursing care for up to 86 people. The home is on three floors and has four separate units each with separate dining and communal areas. All bedrooms are single occupancy and have en suite facilities. The service provides support to adults who have a physical disability, mental health needs, behaviour support needs, dementia and complex nursing needs. At the time of our visit there were 66 people living in the home.

The service had a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like

Summary of findings

registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run.

We found on the day of our visit, 11May 2015, that there was an adequate level of staff on duty to meet minimum requirements. However the evidence we saw indicated that this level of staffing was not always being maintained as nursing staff levels were not consistent across all units that required nursing support and leadership. This meant the levels of care support people received was inconsistent.

We also noted that one to one support provided to people assessed as needing this was not consistent either with different staffing arrangements on different units. This meant that some people might not get the level of individual support and supervision they had been assessed as needing.

We found that staff and the registered manager were working hard to try to maintain a safe service and to recruit and retain suitable staff. We could see that the use of agency staffing was decreasing and the registered manager anticipated that within a period of weeks there would no longer be a need to use agency support staff as new staff started.

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?

Aspects of this service were not safe.

The approach that was being taken by the registered provider did not always provide enough staff with the right skills to be sure people were always safe.

Where people were assessed as requiring one to one support, this was not consistently provided.

The support people received was inconsistent.

Requires improvement

Heron Hill Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008 to look at the overall quality of the service and to provide a rating for the service under the Care Act 2014.

We undertook this focused inspection of Heron Hill Care Home on 11 May 2015 after we received concerns from other agencies and individuals in relation to staffing of the home. This focused inspection was done to look at how the registered provider was assessing and managing staffing levels and skill mixes on the different units in the home and how they were ensuring individual support was provided where required. We looked to see if the staffing levels were being determined by the skills needed to meet people's individual needs.

We inspected the service against one of the five questions that we ask about services: is the service safe. This is because the concerns raised relate only to this domain. We visited all the four units on the home but spent most of our time on Cavell unit where people were living with dementia and also Baden Powell unit which is a male only unit for nine people whose behaviour could challenge the service.

The inspection was undertaken by two Adult Social Care inspectors on an early morning visit to the home to see how the units were being staffed on night and day shifts and to speak with both day and night staff. Before our inspection we reviewed the information we held about the home and concerns raised with us by members of the public and the action plans sent following our previous inspection. We also had contact with the local authority quality management team and the Clinical Commissioning Group (CCG) and health care professionals who provided care and support to people living there.

We spoke with the registered manager, two registered nurses and four care staff on night duty and three registered nurses and five care staff on day duty and with two ancillary staff. We observed care and support in communal areas as people were getting up and having breakfast. We also looked at staff rotas for the service for the last six weeks.

Requires improvement

Is the service safe?

Our findings

At the last comprehensive inspection 12 and 22 October 2014 we had found that staff numbers and skill levels fluctuated on units and staff were moved to work on different units with people whose needs they may not be familiar with. At that time this was presented by the registered provider as contingency planning to maintain the minimum staff establishment. This had been implemented to help relieve the staffing pressures being experienced and was not a long term solution to the staffing problems.

We found at this responsive inspection that staff levels and skill mixes on some units were still not consistent and stable. We saw that staff were moved between units and agency staff were still being used to try to maintain safe staffing levels units and meet the minimum requirements of the regulations. On the day we visited there were nursing staff on day duty on all the units providing nursing care. However that was not always the case across the week for the people living in the home.

This was an early morning visit and many people were still in bed or receiving personal care and so could not easily speak with us. People who were up were being offered drinks and breakfast or toast if they wanted this. Some people who were living with dementia were not able to tell us their views and experiences. We observed examples of supportive and positive interaction by staff during the visit and that people were being treated with respect.

We spoke to a range of staff and their comments indicated that it was predominantly the lack of nursing staff that was causing difficulty in maintaining nursing support and leadership on some units. We were told, “They only need one nurse to go off and its chaos”. They told us that people calling in sick at short notice also caused problems with staffing in the home.

We could see from rotas that there were frequent changes to them and that they were closely monitored by the management team every day and that ‘shift control’ was used to try to deploy staff where they were most needed. Staff were being moved to cover units to try to keep a minimum level of staffing based upon the registered provider’s own staffing model.

The registered provider used a staffing model throughout the home that was based upon there being a member of nursing or care staff provided for every five people on a unit. This was what they worked to maintain. The approach being taken was still a reactive one and did not demonstrate a systematic approach to determining the number of staff and the range of skills required in order to consistently meet the needs of people using the service and keep them safe at all times. We could see from the care plans on all the units that there were people living in the home with complex needs and high levels of dependency. We found that the approach that was being taken was not one that considered the levels of registered professional and support workers needed and the leadership requirements on all units.

On the day we visited we found that there was a registered mental nurse (RMN) on the male only Baden Powell unit that morning until 2pm and they had support from two care staff. Thereafter the registered general nurse (RGN) on Cavell unit, that was next door, provided nursing care and leadership on Baden Powell and administered medication on both units. We saw that four days of the following week there was no permanent RMN and RGN on the unit day or night.

The registered manager told us that an RMN who worked two days on Baden Powell had resigned so the staff level had dropped but they had recruited an RGN to do two twelve hour shifts. They were not on rotas as they had not undergone all necessary checks and induction. Even when they were in post there would still be at least two days each week where there was no RMN or RGN based on Baden Powell unit. The registered manager told us that it was their aim to recruit to provide nursing cover on days seven days a week on Baden Powell. However this had been the aim since our inspection in October 2014.

We found that RGN’s on day and night duty on Cavell, were providing nursing cover and care on Baden Powell up to four days each week and every day after 2pm. The RGN counted as one of the staff numbers on Cavell unit. This meant that they worked as one of the team providing personal care and also nursing interventions, medication administration and took responsibility for maintaining care plans and updating care records across both units. They also had to plan and prepare for any new admissions, do effective assessments of people’s needs and spend time doing this with the person and their families.

We also found this on other units providing nursing care where nurses no longer had dedicated time set aside for

Is the service safe?

management or administrative tasks. Despite this admissions were still being taken onto the units at least one per week but no dedicated nursing time allowed for this. This did not indicate to us that the staffing levels and skill mix were being continuously reviewed by the registered manager and adapted in response to changing needs and circumstances in order to try to ensure safe care was provided.

We discussed this with the registered manager who told us about their plans to look at the structure of staff deployment and use care staff differently to support the nursing staff and so free up nursing time. This would require additional training to develop the support and record keeping skills and competency assessments for senior care staff to acquire the skills to do this safely. Therefore it was not of immediate benefit in relieving the additional work pressures on the nursing staff. The registered manager also told us that the management team were available to provide support to nurses on the units. However we could see that they had their own workload to attend to so this may not be a reliable source of support.

We looked at how one to one support was being provided to people living with dementia who required this level of support. On McKenzie unit only one person required this individual support for a six hour period during the day and there was an extra member of staff allocated to provide this. On Cavell unit one to one support and supervision was assessed as required for four people on the unit amounting to18 hours per day.

We asked staff on Cavell unit how they organised to make sure they provided one to one support for the four people who needed this during the day. We were told it was a "team effort" by all the staff and it was not "nice and neat" but done between them. They told us they had to make sure one person stayed awake, check that one person remained in their chair and said that one did not like being closely observed so they just kept them in sight. We saw one staff member providing one to one support to a person and also supporting another person who needed the same level of individual support. This was not the level of individual support we saw on McKenzie unit and there were not sufficient staff free to give that agreed level of support continuously on Cavell unit.

We were told by staff that "We are at the bare minimum, you really can't do the extras and it's sad because the quiet ones just don't get the attention" .We were struck by the commitment of a core permanent staff group to provide good care and we were told that "The [registered] manager really does his best". Staff told us that they felt Cavell was "A good unit, we have come on in leaps and bounds". However we could see that staff morale was low and care and nursing staff were under pressure to meet workload expectations.

We found that the registered manager was actively recruiting and taking steps to attract more permanent nursing and care staff and in some respects the staffing situation were improving as more staff were being recruited. We could see that the use of agency staffing was decreasing and the registered manager anticipated that within a period of weeks there would no longer be a need to use agency support staff. This was when the new support staff came on the rotas.

However the rotas, staff experiences and our observations of one to one support and the way skill mix and staff deployment was approached indicated that the original short term staffing contingency plans and daily staff monitoring put in place 12 months ago were still in daily operation. This indicated to us that after being in operation for such a period that they were no longer emergency staffing measures but had now become the normal approach to managing staffing in the home. If this approach was the rule rather than the exception then that could put people at risk.

This was a breach of Regulation18 of The Health and Social Care Act 2008 (Regulated Activities Regulations 2014 because staffing levels were inconsistent and not maintained at a level that ensured the safe delivery of care at all times.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **Regulation 18 HSCA (RA) Regulations 2014** **Staffing.** **How the regulation was not being met:** **People were placed at risk of harm because the registered provider did not have effective systems to ensure they consistently deployed sufficient numbers of suitably qualified and skilled staff to make sure that people's care and treatment needs were always met.** **Regulation 18 (1)**