

Miss V Etheridge

Heronlea Residential Home

Inspection report

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NR13 5DS

Tel: 01603713314

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Ratings

Overall rating for this service

Good ●

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?

Good ●

Summary of findings

Overall summary

This inspection took place on 23 May 2017, and was unannounced.

Heronlea is a residential care home which provides accommodation and personal care for up to 13 people. At the time of our inspection, there were 11 people using the service.

There was a registered manager in post. 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 range of activities available were not always appropriate or stimulating for people living with dementia. They did not meet people's individual or specialist needs.

Staffing level arrangements were being reviewed by the registered manager to ensure they met the needs of people using the service at all times. Staffing levels were observed to be adequate throughout the day, and staff were available when people needed support.

People were supported to eat sufficient amounts and maintain a balanced diet. However, improvements were needed in the lunchtime experience for people, and we have made a recommendation about this.

The service was meeting the requirements of the Mental Capacity Act 2005 Deprivation of Liberty Safeguards (DoLS). Staff understood the need to obtain consent when providing care.

Staff respected people's privacy and dignity and interacted with people in a kind and caring manner.

Risk assessments were in place in respect of people's care, treatment and daily living.

Staff knew about how to safeguard people from abuse and what to do if they suspected abuse was occurring. Safe recruitment procedures were in place, and staff had undergone recruitment checks before they started work to ensure they were suitable for the role.

There was a complaints procedure in place for people to access if they needed to.

People were protected by safe processes in place in respect of the storage, administration and recording of medicines. Staff received training and their competence was periodically assessed.

There were systems and processes in place to support the safety and quality of the service.

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. They were supported by staff who had received pre-employment checks to ensure they were suitable for the role.

People's medicines were administered and stored safely.

Risks to people were identified and plans were in place to reduce the risks.

Is the service effective?

Good ●

The service was effective.

People were supported by staff who received training to carry out their role.

Where people lacked capacity to make decisions for themselves, processes were in place to protect people's rights. However, mental capacity assessments were not always completed alongside decisions which were being made in people's best interests.

People were supported to eat a balanced diet, but the mealtime experience for people could be improved.

People were well supported by health and social care professionals.

Is the service caring?

Good ●

The service was caring.

People were supported by staff who knew them well.

Relatives could visit when they wished and there were no restrictions.

People were supported by staff who understood the importance of privacy and dignity.

Is the service responsive?

Some aspects of the service were not fully responsive.

The provision of activity was not always appropriate or stimulating for people living with dementia, and was not at a level which would meet the individual and specialist needs of all people using the service.

Care plans needed to be developed to fully reflect people's life history and social care needs.

There was a complaints procedure in place

Requires Improvement 

Is the service well-led?

The service was well-led.

Systems were in place to monitor and improve the quality of the service for people. These systems were being reviewed to ensure they were robust and covered all aspects of the service.

Aspects of the service which needed improvement, such as care planning and the provision of activities, needed to be actioned to ensure it was meeting people's needs.

Staff felt supported and able to raise concerns to the registered manager.

There were systems in place to ensure regular feedback from people, relatives, staff, and professionals.

Good 

Heronlea Residential 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 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 took place on 23 May 2017, was unannounced and undertaken by one inspector 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.

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 also reviewed information we had received about the service such as notifications. This is information about important events which the provider is required to send us by law. We also spoke with community health and social care professionals, and local quality assurance and safeguarding teams.

During the inspection we spoke with six people living at the service and one relative. Some people were living with advanced dementia, which meant they could not always readily tell us about their experiences, but we observed the way they interacted with staff and how they spent their day. We spoke with the registered manager, an external consultant, and four members of care staff. We also observed the interactions between staff and people throughout the day. After the inspection we spoke with a further two relatives, a social care professional, and a health professional.

To help us assess how people's care needs were being met we reviewed three people's care records and other information, including risk assessments and medicines records. We reviewed three staff recruitment files, maintenance files and a selection of records which monitored the safety and quality of the service.

Is the service safe?

Our findings

People we spoke with told us they felt safe living in the service. One person said, "I feel safe here because of the staff; they are very kind." Another said, "When there's several of you together you always feel safe don't you." A relative told us, "I don't have any worries about my [relative] here. The staff are good and I know them all."

Staff had received safeguarding training and were able to identify different types of abuse and what action they needed to take if they suspected someone was being abused. One staff member said, "We [staff] are always on the lookout for signs of abuse. It's not always the more obvious things like physical abuse; sometimes it can be less obvious like emotional abuse. First and foremost I would report it to my manager, and expect it to be taken seriously. If it wasn't, I could go above them, or outside to the safeguarding team." Another said, "I would raise any concerns I had to the manager, or outside agencies."

People's care records included risk assessments and guidance for staff on the actions that they should take to minimise risk. These had been reviewed to ensure any needs which had changed were updated. These included moving and handling, falls, nutrition, and skin integrity. Outcomes of risk monitoring informed the care planning arrangements, for example weight loss prompted onward referrals to dietetic services, and where people were at risk of developing pressure ulcers, pressure relieving equipment had been provided.

Risks to people injuring themselves or others were limited because equipment, including electrical equipment and hoists had been serviced and checked so they were fit for purpose and safe to use. There were systems in place to monitor and reduce the risks to people in relation to the water system and legionella bacteria

Personal Emergency Evacuation Plans (PEEP's) were recorded within people's care records. These showed the individual support people required to evacuate the building in an emergency situation. Environmental checks on the fire alarms and fire fighting equipment were undertaken monthly.

Staff told us that there were enough staff on shift to meet people's needs. One staff member said, "It seems to work well here. Staffing levels seem adequate, and we can always knock on [registered manager's] door if we need an extra pair of hands." Another said, "Staffing is fine. If we are supporting a person who needs two staff, then [registered manager] comes out immediately. People tend to get up at different times, so that staggers the support people need from us."

The registered manager told us that staffing levels had been increased between the hours of 7am to 9am, as this was the busiest time of the day. They told us they had discussed staffing levels with the local quality assurance team, and that they indicated that the levels of staff were adequate. However, there was no system in place to establish whether staffing levels were adequate, such as a dependency tool. The registered manager showed us that they had been given a dependency tool from the quality assurance team which they could use to determine staffing levels, and were in the process of completing this. Our observations were that that staff responded to people's needs in a timely manner (this included responding

to requests for assistance, assisting people with eating, and spending time chatting with people during the day).

There were safe medicine administration systems in place and people received their medicines when required. Staff had received training in medicines, which included annual competency checks. We saw that medicine administration records were accurately and consistently completed by staff to show what medicines people had been given and when. One person said, "They [staff] bring my tablets regularly, that's all ok."

Medicines were stored securely, with appropriate facilities available for controlled drugs and temperature sensitive medicines. For people receiving medicines "as required", there were protocols in place for staff to follow on when to offer these medicines. This information is also useful where people may not be able to verbalise how they are feeling, and provided staff with information, such as symptoms a person may display if they were in pain, or in one case, if their temperature went above a certain level.

Is the service effective?

Our findings

Systems were in place to ensure that staff were provided with the training necessary to carry out their role effectively. This included dementia awareness, the mental capacity act, first aid, medicines, moving and handling and health and safety. The registered manager told us that staff in the service held qualifications in care, and had also been trained to undertake basic health checks where people were feeling unwell or when a GP visit had been requested. This included taking people's blood pressure, temperature, saturation levels (amount of oxygen in the blood) and undertaking urine tests. This information was then passed to the GP prior to or during their visit. This assisted the GP in identifying any apparent causes to people's ill health symptoms. A health professional told us, "Whenever [Heronlea] request a visit, I know it's necessary. They [staff] always seek advice when necessary about people's health."

Staff new to the service completed a staff induction, which consisted of mandatory training and shadowing of more experienced staff. One staff member told us, "My induction was very good. The staff were friendly and the [registered] manager approachable." Staff told us they received regular supervision. These sessions discussed staff progress, reflected on their work, and identified training needs. One staff member said, "I get regular supervision every six to eight weeks." Another said, "My first supervision is due soon with [registered] manager. We looked at two supervision records, and saw that relevant items had been discussed, such as training needs, safeguarding issues, recording on documentation and any identified improvements that were needed."

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any decision 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). The MCA DoLS requires providers to submit applications to a 'Supervisory Body' for authority to restrict people's liberty.

We saw that DoLS applications had been made to the local authority as required to ensure that any restrictions on people were lawful. However, there was a lack of documentation to show how the decisions taken had been made in the person's best interests. For example, the reasons why a DoLS was the least restrictive option to ensure the person's safety, and if other options had been considered.

People (or where agreed, their representative) had signed to consent to the care and treatment they were receiving. Where people had legal representatives in place, these were documented, and included what legal authority the representative held.

Where people lacked the ability to consent to day to day tasks such as personal care, eating, safety, and

well-being, best interests decisions had been made on the person's behalf. This included a summary of why the decision had been made in the person's best interests. We saw that relevant people had been involved with the decision making where appropriate.

The three records we sampled stated; "Please gain consent for everything you do for me." This was a reminder to staff to always check people's understanding of the proposed task and wherever possible to gain consent.

Staff had received training in MCA, and understood the importance of gaining consent. One staff member said, "Everyone is different, and every day is different. One day the person may not be able to make the decision, but the next they might. It's about the here and now, and what is in people's best interests." Another said, "I never do anything without asking people's permission first, whatever the task is." We also observed staff asking people for consent before they assisted them with tasks such as helping people to eat, moving from their chair, or assisting with personal care tasks.

People were supported to eat sufficient amounts and maintain a balanced diet. Where people required assistance, they were supported to eat and drink. This included keeping records of their food and fluid intake when there were risks. Where people required food supplements to increase their weight, we saw this was provided. We also observed that people were offered drinks throughout the day.

We received feedback about the food. One person said, "Yes it's okay. They feed me well and there's plenty of it." Another person told us, "If I was hungry I would tell them [staff] and they would come up with something."

We observed the lunchtime meal which was served in the main dining area. Food was served directly from the kitchen, and we spoke to the cook who told us they knew people's preferences well. We saw that there was a list in the kitchen of people's likes and dislikes of certain foods, and that some people had stated a preference for soft mashable or liquidized foods. However, we noticed that all people were served the same portion size, which was a fairly large plate of food. Most people did not eat all of their food, and we considered that for some people the size of the meal may be overwhelming, and that individual preference with regard to portion size may not be fully understood. The cook told us that this was considered, but most people had a good appetite.

Soft drinks were served at the table before the food arrived, and once people were seated the food arrived promptly. One person needed a lot of help with seating, and we saw that staff were patient and communicated well to provide guidance. A member of staff brought in their own lunch to eat at the table with one person. They observed people to ensure they were able to manage, and where one person appeared to have no motivation to eat, they moved to another table to assist them. However, there was very little conversation or activity during the meal, which would enhance the atmosphere and experience for people. Two people chose to eat outside. Tables were laid with condiments but nothing else to indicate that lunch was about to be served, such as a table cloth or cutlery. Setting up the tables fully would support people living with dementia to recognise that lunch was about to be served.

We recommend that the service explores current guidance from a reputable source to ensure that mealtime experiences are an opportunity to support and promote independence, in addition to creating a positive mealtime experience, particularly for those with specialist needs including dementia.

People had access to health care services and received on-going health care support where required. We saw that referrals to relevant professionals were done so in a timely manner, and where needed, further

advice had been sought. This included dieticians, district nurses, respiratory teams, occupational therapists, and physiotherapists. One relative told us, "Last week my [relative] had an infection. They had urgent antibiotics straight away. The staff were straight in there." A social care professional said, "If ever I have a person who I'm trying to place [in a residential home] who is quite complex, I always think of Heronlea. They are very flexible in meeting people's needs."

Is the service caring?

Our findings

People told us that staff were kind and respectful towards them. One person said, "The staff are very good and they treat me with respect." Another said, "The two staff today are very nice and you can always talk to them." A relative told us, "I am more than happy with the staff here, they look after my [relative] well." A social care professional said, "Very person-centred approach at Heronlea."

Staff knew people well, and people appeared relaxed in their company. Staff told us they had built up positive relationships with people and spoke about them in a respectful manner. One staff member said, "I love working here, we get to know people well." Another said, "This is a 'home', it's not like the typical institutional type of place. I think because it's small we make it more homely for residents."

We observed the way people interacted with the staff. This included how people responded to their environment and the staff who were supporting and communicating with them. During the day we saw staff spending time chatting with people outside in the garden area, and people were enjoying friendly banter with the staff as they were getting ready to eat their lunch time meal.

There were no formal 'resident' or relative meetings held in the service. The registered manager told us that due to the small size of the service, and people's differing ability to contribute in a formal meeting, they informally spoke to people on a one to one basis to ensure people's views were known. There was therefore no way to review the effectiveness of this approach in ensuring and demonstrating people were actively involved in their care. However, care plans did demonstrate that the person's views had been sought and were very detailed in areas such as how the person liked their personal care delivered. For example, one person liked to be presented in a certain way. It included how it was important to the person to wear make-up and choose their own clothes. A relative told us how the staff regularly updated them. They said, "They [staff] always tell me how [relative] has been. I don't need a separate meeting to do that, I'm quite happy with the arrangement."

As many of the people had lived in the service for a long period of time, staff knew people well, their likes and dislikes and preferences for how their care was delivered. One person told us, "The staff come and talk with me, especially [registered manager]." The registered manager told us they were always trying to think of new ways to gain people's views. They told us a 'comment box' had been introduced in the reception area to gain people's views; however, this had not been used by anyone living in the service, and we felt that some people would be unable to walk through to find this. Others would be unable to express their views in writing due to the effects of their dementia. The registered manager told us they would continue to review their approach to ensure people have as much opportunity to express their views as possible.

The importance of people retaining aspects of their independence was reflected in their care plans, such as which areas of personal care the person could still manage independently, and where they required support.

Privacy and dignity was respected, and we saw that staff attending to people's personal care ensured that

doors and curtains were closed. Where people were sharing a room, there was a screen dividing the room which ensured privacy when needed. When staff were speaking to us about people, this was done so in a discreet manner so others close by were not able to hear.

Relatives were permitted to visit at any time, and spoke positively of the service. One relative told us, "I come in every day to visit my relative, I'm happy to come and go as I please."

Is the service responsive?

Our findings

The approach to supporting people with their interests and to have meaningful and fulfilled days needed improvement. There was not a dedicated activity co-ordinator; the expectation was that care staff would provide activities for people in addition to their caring duties. During the morning we observed one person having their nails painted, and three others sitting outside with a staff member. In the afternoon we saw staff playing cards with two people. Staff were seen to have the time to chat with people throughout the day, but were not always using this time to engage in a meaningful way. People living in the service had become accustomed to their daily routines and did not question how their time was spent. However, when we asked people it was clear they wanted more to do. The feedback we received did not reflect that the provision of activity was meaningful or meeting people's individual needs. One person said, "I just sit. I get fed up sitting here all day. I sit in this chair all day and it gets me down." Another said, "I spend my day just sitting and watching television and talking to anyone who goes by."

The registered manager told us that they had tried to introduce different activities, such as gardening, cooking, and household tasks people could attend to, but people lost interest after a while. However, when we spoke with people we found that several of them had ideas of activities they would like to take part in, such as archery and singing. Others were unable to come up with specific ideas for what they would like to do, but it was not clear whether other options had been considered for people who did not wish to take part in practical activities, such as sensory stimulation.

We saw that when people did engage with staff they responded in a positive way, smiling and talking. However, in between these times people were sat for periods of time and were disengaged with their surroundings. We could therefore not be assured that there was sufficient activity provision across the service to meet people's individual and specialist needs.

Some care plans contained a "Personal fact file", which asked the question, "How much do you know about the person with dementia?." Some information was recorded such as people's employment history, their family, favourite drinks, music and what helps them to relax. However, this was very brief information which could be built upon. The registered manager told us that when a person came to live at the service, family members were asked to complete the fact file to help build up a picture of the person's life history. However, some people did not have family, and therefore it had been difficult to gain this information. The registered manager had tried other ways, such as contacting social care professionals involved in arranging people's care, but for some people this information had not been available.

Other areas of the care plan included information on "Social networking", but again this held only very brief information about the person, for example, how many times the person had been married, and that they had two children. Having more detailed information supports staff to have meaningful conversations with people about their lives and what was important to them. There was limited information about what brought wellbeing to people's lives, particularly for people living with dementia. This information could be used to identify possible areas of interest for people, which could then be linked to individual activity.

We spoke to the registered manager who had identified this as an area for improvement. They told us that they were trained in "dementia mapping" (A process which involves observing people throughout the day to identify things which create happiness or distress for them) and was planning to undertake work on this. This information can be used to ensure that people have the opportunity to experience well-being more often during their day and assess more fully what particular aspects of daily living brings well-being to people living with dementia.

People's care records included care plans which guided staff in the care that people required to meet their needs. This included emotional needs, nutrition, personal care, mobility, and communication. These were personalised and reflected people's abilities.

The service had a complaints procedure in place and details on how to complain were displayed in the main reception. We asked people if they knew how to complain, and one person told us, "I've never had a problem but if I had I would tell the staff. I wouldn't have any worries about it, none at all." A relative said, "I'm sure I can complain, but I just speak with the manager so often any issues would be raised with them directly."

Is the service well-led?

Our findings

The registered manager was also the registered provider and had worked in the service for a number of years. The culture in the service was welcoming and friendly, and the registered manager was open and transparent with regard to what improvements were needed in the service. This included how they needed additional support to ensure compliance standards could be met. The registered manager did not have a formal deputy to assist with the day to day running of the service, but was covered in their absence by a member of staff who held leadership qualifications. They had also recently appointed an external consultant. They were supporting them to improve the current quality assurance processes, and seek advice on other areas of the service, such as care planning and activity provision.

The registered manager acknowledged that improvement was needed for people to take part in meaningful activities, particularly for people who were living with dementia. The registered manager was knowledgeable about dementia and the benefits of 'dementia mapping' but had not yet undertaken this work to see how people's lives could be enhanced due to covering shifts where there had been staff sickness. The provision of activity was linked around staff availability and their timetable. For example, staff were busiest in the morning, so activity would always begin after they had completed their caring duties, whereas, activity should be tailored to people's individual choice regardless of the time of day. We discussed the importance of a more flexible approach with the registered manager.

The registered manager held a leadership qualification, was a mental capacity trainer and a dementia champion [a person with increased knowledge of dementia]. They also worked as a member of staff on shift, and staff told us they helped out when needed. One staff member said, "[Registered manager] always helps when needed, they are always available." A social care professional told us, "I love the service [registered manager] provides. They are really supportive, and they always come and visit the person in their own home before they move in. They go the extra mile. [Registered manager] repeatedly visited one person so they could build up a relationship with them". A health professional said, "[Registered manager] has a big heart. They will do anything to get the proper care for people."

Staff showed a good understanding of their individual roles and spoke to each other throughout the day as to what was happening and what needed to be done. We observed that they were kind and caring towards people who used the service, and supported people in a patient manner. Staff told us they felt able to speak up and raise concerns with the management team. One staff member said, "I think [registered manager] is very good. Much better than previous places I have worked at. I am listened to and the communication here is very good." Another said, "The [registered manager] thanks you when you do a good job. I feel involved with what's going on." A relative told us, "[Registered manager's] attitude is spot on. Professionalism is good, and interacts well with me and [relative]."

We saw that a wide variety of audits were in place. These were part of a new auditing system that had been recently introduced and included health and safety, medicines, infection control, risk assessments, and environmental checks. Though audits were being carried out previously, the registered manager told us they needed to be more robust. For example, the previous medicines audit was presented as a tick list, the new

one allowed for comments to be made, and could identify more easily if quality was being compromised.

Changes were being planned as a result of the various audits, for example, dimmer switches were going to be introduced so it was better for people when night time checks were being carried out by staff, and one person's room had been identified as needing to be redecorated. Audits of care plans were not currently being carried out, but we saw that an audit had been planned, and that the registered manager was aware that some information did not need to be held in care plans [such as documentation which could be archived]. This will ensure the care plan is compact, and contains only relevant key information about people and how they prefer to have their care delivered.

The registered manager told us that people's views were important to them, but often found it hard to gain people's views as some were living with dementia and had no family members. We saw a discussion had taken place to look at different methods of gaining feedback from people, and this was going to be discussed with the external consultant to see how this could be improved. Surveys had been recently sent out to staff and professionals, and they were awaiting feedback.