Four Seasons (Evedale) Limited

Heath House

Inspection report

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Ratings

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

Overall summary

This unannounced inspection took place on 9 and 10 of September and we returned to provide feedback on 14 September 2015. Our last inspection was in April 2015 when we found that the care and support people living at Heath House experienced was inadequate. Following the inspection we met with the registered provider and commenced using our enforcement powers. The registered provider sent us an action plan detailing how they would improve to ensure they met the needs of the people they were supporting and the legal requirements. This inspection identified that some improvements had been made. However we also identified some serious concerns for the welfare of people whose care we looked at in detail.

Heath House is a nursing home that can accommodate up to 50 people between two units called Walkers and Heath. Everyone had needs relating to their older age, and some people were also living with dementia and mental ill health. At the time of our inspection there were 27 people living at the home.

A new manager had recently been appointed to Heath House. They had applied to the Commission for registration. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered

Summary of findings

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.

Our inspection identified that changes and improvements had occurred across the service. The actions taken had reduced some of the risks to people's safety but inconsistency meant that people were not always safe. For instance the techniques used to move and support people with their mobility were not always in line with good practice and could cause injuries to both the people being moved and the staff involved. The two people we observed being supported using unsafe techniques had bruises that could have been caused by this technique. However people who required the use of a hoist to move were supported by staff that had been trained to do this safely.

The management of medicines had improved however people were still not always getting the medicines prescribed to them. People who had been prescribed patches for pain relief had not always had these applied correctly which may have resulted in them experiencing more pain than necessary.

The number of staff available to support people had improved however people were not always supported by the right number of staff in the right place at the right time. This meant people sometimes had to wait a long time for support.

People had been supported to see a wide range of health care professionals. However people had not always received the support they required with both their psychological and physical health care needs. The inspection identified concerns for people who were at risk of constipation, at risk of developing sore skin and who were anxious and depressed.

The quality of the food and drinks offered to people had improved. However people were still not getting all the help they required to drink enough to stay healthy.

Most people told us that they liked the staff that supported them and people's relatives confirmed this. We observed occasions when staff did not uphold people's dignity or privacy. People approaching the end of their life were cared for with compassion by staff but their care and wishes were not well planned or recorded.

People who found it hard to join in activities and who were at risk of becoming isolated were not being supported by staff that had the specialist skills and experiences to provide this support. People did not have opportunities to take part in hobbies or activities they had enjoyed in their earlier life. Opportunities for people to take part in home based activities such as craft, nail care and reminiscence had increased, and some people told us they were enjoying this.

There was a more effective system in place to identify, record and report on complaints. This had resulted in concerns that had been brought to the manager's attention being dealt with effectively and thoroughly.

Changes had taken place in the management staff team. The new regional manager, home manager and deputy manager all showed a strong commitment to the on-going improvement of the service. Although changes were evident in all areas we inspected these had not been adequate to ensure the safety and wellbeing of people living at Heath House or the smooth running of the home.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of

Summary of findings

inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

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?

Inadequate 

The service was not safe.

People could not be confident they would always be supported to move in a way that was safe and that would not cause them harm.

People could not be confident they would always receive the medicines that had been prescribed.

People could not be confident that risks to their wellbeing and safety would be identified and well managed.

People could not be confident that there would always be enough staff in the right place at the right time to meet their needs.

Is the service effective?

Inadequate 

The service was not effective.

People could not be confident they would always get the support they required to drink enough fluids to stay healthy.

People could not be certain that their care needs would always be well planned, delivered or recorded to ensure they maintained as good health as possible.

The requirements of the Mental Capacity Act 2005 were not always being adhered to, which meant people could not be sure their human rights would be upheld.

Is the service caring?

Requires improvement 

The service was not consistently caring.

Most people were supported by care staff they liked and who demonstrated kindness to them.

People could not be certain they would always be supported by staff that would maintain their dignity.

People approaching the end of their life did not receive care that was planned in ways that met their wishes, or good practice guidelines.

Is the service responsive?

Requires improvement 

The service was not consistently responsive.

People did not have access to activities and opportunities that would provide stimulation or that would help them continue hobbies and interests they had enjoyed in earlier life.

Summary of findings

There was a system in place to identify report and investigate concerns. Relatives and people we spoke with felt able to raise their concerns with the manager or nursing staff.

Is the service well-led?

Inadequate 

The service was not well led.

There were inadequate systems in place to facilitate effective communication between staff. This had placed people at risk of inappropriate or unsafe care.

The systems to check on and drive improvement were not effective, and had not identified potential risks to people's safety or the continuity of care. They had not been effective at ensuring people would receive their care consistently, safely or in the way they preferred.

Records were not completed or stored in a way that would inform staff about people's needs or enable staff to monitor and evaluate progress made towards people's care or life goals.

Heath House

Detailed findings

Background to this inspection

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

This unannounced inspection took place on 9 and 10 September and we returned on 14 September 2015 to provide feedback.

The inspection was undertaken by inspectors from the Care Quality Commission, a specialist pharmacy inspector, a special advisor who had knowledge about the needs of older people, and an expert by experience who had knowledge of supporting older people.

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

During the inspection we spoke with 20 people who lived at the home. Some people's needs meant they were unable to verbally tell us how they found living at Heath House, and we observed how staff supported people throughout the inspection.

We spoke with four health care professionals, the relatives of nine people, the manager, representatives of the registered provider, and 15 staff which included both registered nurses and care staff. We looked at parts of the care records for eight people. We looked at the medicines management processes and records maintained by the home about staffing, training and monitoring the safety and quality of the service.

Inadequate

Is the service safe?

Our findings

We last inspected this service in April 2015. At that time people were not safe. We told Four Seasons (the registered provider) that the actions they had taken to keep people safe were inadequate and we commenced enforcement action to ensure that legal regulations would be met and the necessary changes made to ensure that people living at Heath House would be safe. We returned to inspect Heath House in September 2015 and found that some improvements had been made. On some occasions and in some circumstances people's safety had improved but these improvements were not enough to consistently assure people's safety.

At our inspections in December 2014 and April 2015 we had observed staff using techniques to move people that could cause an injury to both the person and the member of staff. During our inspection we again observed some moving and handling practices that could cause people harm. We saw people being offered support to stand up from their chair. The techniques used could cause both the person or the member of staff to injure themselves. We saw two people had bruises on their hands which could have been caused by using this inappropriate moving technique.

People's needs and the risks associated with helping people to move had been assessed and recorded in each person's file. We looked at five people's care in detail, and three of these people were supported to move using a different technique or without the equipment they were assessed as requiring. Care staff we spoke with were not aware that the support people needed or that the contents of the written documents had changed. Failing to help people move safely was a breach of the Health and Social Care Act 2008. Regulated Activities Regulation 12.

We observed improvements had been made to the support given to people who required the support of a hoist to move. In these instances we observed people being supported by staff that were confident and had been trained to use this equipment safely. We observed staff offering people reassurance and explaining to them what was going to happen.

People living at Heath House required the nursing staff to manage and administer their medicines. In December 2014 and April 2015 we found that this was not being undertaken safely and people could not be certain they would always receive the medicines they had been prescribed. At this inspection whilst we observed that improvements had been made there were still some concerns about safety. Records and stocks of medicine we looked at showed that some people had still not been given all the medicines they had been prescribed, and for two people we found the medicine had not been used as directed.

People who had been prescribed medicinal patches had not had these applied following good practice guidelines. This may have reduced the effectiveness of the medicinal patch which had been prescribed to help manage the person's pain.

One person whose care we looked at in detail suffered from chronic constipation. Staff had not given all of the laxative medicine that had been prescribed by the doctor. The person's records and records of examinations showed the person may still have been experiencing constipation, and failing to use all the prescribed medicines may have resulted in this person's constipation getting worse.

Records showed that another medicine had not been given as prescribed. This medicine had been prescribed to reduce the production of cholesterol. Failing to administer it as prescribed increases the risks associated with coronary heart disease.

We also found two medicines that had not been stored safely in line with manufacturer's advice. This would have reduced the effectiveness of the medicine.

We looked for evidence that topical creams had been applied as prescribed. The medicine recording charts had not all been signed to confirm the cream had been administered. For one of the people whose care we looked at in detail 29 out of 48 applications had been missed. In all of these instances the systems and checks to ensure safe medicine management had failed to identify these issues. This was a breach of the Health and Social Care Act 2008. Regulated Activities Regulation 12.

We observed nursing staff spending time helping people to take their medicines, and when possible explaining to them what they were being offered and what the medicines were for. Staff wore a tabard stating they were administering medicines. This was respected by staff and visitors and was a way of decreasing distractions to staff administering medicines. This would reduce the risk of a medicine error being made.

Inadequate

Is the service safe?

In December 2014 and April 2015 we found that people were not being protected from abuse and improper treatment. This included staff failing to provide care or treatment when it had been assessed as required and planned for the person. In September 2015 we observed unexplained bruises on people's hands and body. Discussions with staff, the management team and reviews of records failed to identify when these injuries had happened. The injuries had not been reported or recorded and subsequently no action had been taken to ensure the person's wellbeing or to investigate the injury. Failing to protect people from improper treatment and failing to have systems in place that would investigate such treatment is a breach of the Health and Social Care Act 2008. Regulated Activities Regulation 13.

We had previously raised concerns about the numbers of staff on duty, and had found evidence that the number of staff on duty was not adequate to safely and effectively meet people's needs. At this inspection we observed improvements had been made to the ratio of staff however we still observed occasions where the right number of staff were not available in the right part of the home to provide people with the support they required. Examples of this included one person asking for support to use the toilet. They had to wait 20 minutes for staff to be available to help them. We observed one person preparing to urinate in a communal part of the home. The staff on duty were not providing supervision or support to this person until inspection staff brought the person's needs to their attention. One person we spoke with told us, "Sometimes there isn't enough staff. Last week I had to wait until 11am, you just have to wait your turn." A member of staff told us, "On paper it looks like we are well staffed. Actually people's needs have changed and the assessments are not all up to date." Another staff member told us, "Care is improving but the two staff on Walkers [one of the units within the home] are just not always enough. It means people can be left on their own if staff are helping people that need the help of two staff, and staff don't always get their breaks." Other staff we spoke with confirmed this and gave examples of the support people required when they needed either hoisting, reassurance, were unsettled, or if they required personal care. The staff member went on to explain the needs and risks people currently had that were not detailed in the care plans and risk assessments. We observed on two days of the inspection that people were left in their wheelchairs sitting at the dining room table for up to two and a half hours after the breakfast meal had finished. Staff told us this was because they did not have adequate numbers of staff to support moving people to comfy chairs as other people still required help to get up and attend to their personal care. Relatives we spoke with confirmed that the numbers of staff had improved and their comments included, "Staffing levels have improved and generally there are enough." A member of staff told us, "There have been lots of improvements, mostly with staffing levels. Sometimes it used to take until 2pm in the afternoon to get people up; having more staff means we can give better care." Our inspection provided evidence that staffing had improved but there were still not always enough staff on duty in the right place at the right time. Failing to have adequate numbers of staff to meet people's needs is a breach of the Health and Social Care Act 2008. Regulated Activities. Regulation 18.

We looked at the recruitment files of two members of staff that had recently commenced work at the home. We found that the required checks had been made to ensure that the candidates were suitable to work in adult social care before they started work in the home. One member of staff who had started work at Heath House recently confirmed that recruitment checks had taken place.

We asked people if they felt safe and people told us, "It's not so bad", "They're okay to me" and "It's okay except for when staff go on 'naa, naa, naa'. I don't always know what they want me to do." All but one of the staff members we spoke with demonstrated a good knowledge of how to safeguard people. Records showed that safeguarding training had been provided and when this was due to be renewed staff were reminded to ensure they attended the training so that their knowledge stayed up to date. We looked at the induction and training provided for one new staff member and safeguarding training had not been provided for them at the start of their employment. Staff told us they felt people living at Heath House were increasingly safe. They felt this was because some people had been moved to different care homes that better suited their needs and the ratio of staff had increased. Relatives we spoke with told us they felt their loved one was safe at Heath House. Their comments included, "I don't worry about [name of person] at all" and "Yes- I am happy with the care." A member of the nursing staff team told us, "Staff would tell me if they thought someone was being abused, and they would expect me to act. I would follow up with the manager if I thought no action was taken."

Inadequate

Is the service effective?

Our findings

We last inspected this service in April 2015. At that time people were not receiving effective care and support. We told Four Seasons (the registered provider) that the service they were providing was inadequate and we commenced enforcement action to ensure that legal regulations would be met and changes made to ensure that people living at Heath House would receive effective care. We returned to inspect Heath House in September 2015 and found that some improvements had been made. On some occasions and in some circumstances people were receiving effective care but these improvements were not good enough or consistent to ensure people always received the care and support they required.

We had raised concerns at our previous inspections about the amount and quality of food and drinks people were being offered and the support people received from staff at meal times. This inspection provided evidence that the quality and variety of food had improved, and that additional staff had been made available to support people at meal times. However we expressed continued concern about the support and monitoring available for people who were reluctant or unable to eat or drink. We observed some people come to the dining table and leave having eaten nothing or very little. People were not always offered an alternative meal or encouraged by staff to eat. We observed that some people were brought to the dining room up to an hour before the lunch time meal was served. We observed that when the meal was ready, many of the people were asleep, and it was difficult to rouse them and motivate them to eat. We observed a person who became unsettled and anxious in the wait leading up to lunch time. On one occasion we observed staff take prompt, effective action to support the person. On the second occasion this did not happen, and we observed the person become increasingly upset, which then distressed some of the other people in the room. At one meal time we observed a nurse serve fortified drinks to people at 12.50, as they were waiting for their lunch time meal. We questioned the timing of this, as several people took the drink but then declined their meal which was served 30 minutes later, possibly because of feeling full from the build-up drink.

One person we spoke with told us that the food had generally improved but that they were sometimes frustrated at not being able to get the food they fancied or requested. They told us, “I fancied a jacket potato for tea, they [member of staff] said okay but then they forgot. I had one the next day but it wasn’t cooked properly and I couldn’t eat it.” A member of staff we spoke with told us of a similar event, they described the following; “They [member of staff] asked [name of person] what they would like for breakfast. He said ‘Weetabix.’ I saw them bring him cornflakes. When challenged they said they had forgotten what he said. This just isn’t good enough. He didn’t eat them.”

We looked at the records of fluids given and offered to three people who were reluctant to drink, and who would have been unable to independently help themselves or request a drink. We visited one person in their room at 11.00. We continued to monitor the support offered and visited the person in their room throughout our inspection. The person’s drinks in their room remained untouched and were the same at 19.15 as they were at 11.00am. Records showed that although the drinks were untouched the person had taken a total of 270ml fluid from staff during the day. Records showed that staff had offered the person fluids which they had declined, but these interventions were only every two hours. There had been no increase in staff activity to reflect the low amount of fluids accepted during the day. Staff had not explored alternative ways of offering the person fluids in a way that they may have found more acceptable, such as an ice lolly or soup.

Another person whose care we looked at in detail tracked had a daily fluid goal detailed in their care plan to help in the management of a chronic health condition. Records showed the fluid goal set had never been achieved. The monthly evaluations of the care plan failed to acknowledge this and had not caused staff to increase the amount or frequency of fluids offered. The person’s chronic condition was not well managed, and failing to offer the fluids required could have contributed to this. The third person we looked at in detail had two daily records in place. Initially we thought there were significant gaps in the person’s care and food and fluid records but much later were shown a second record that had been archived. This record was for the same time period that filled these gaps. Nursing staff responsible for tracking the amount that this person had been offered to eat and drink were unaware of the two records and would have been unable to accurately monitor the person’s food and fluid intake from the one record that was initially available.

Inadequate

Is the service effective?

Failing to provide adequate food and fluids to maintain good health is a breach of the Health and Social Care Act 2008. Regulation 14.

Since our last inspection additional support had been provided for staff responsible for ordering and preparing food. As a result the meals served had improved in quality for everyone, including meals for people who required their food to be fortified or to be altered in texture. We saw that a wider choice of drinks were available, and meals that catered for people's individual preferences and cultural needs had been made. These improvements had resulted in a weight gain for some of the people who were assessed to be at nutritional risk. A relative we spoke with confirmed their pleasure that their loved one had gained weight, and at the improvements to the food provided. A person living at the home we spoke with told us, "That was a good meal."

We observed staff offering people choices of food either by talking through the different options available or by showing people plates of real food to support their decision making. We observed that breakfast was served flexibly as people were ready to eat. The breakfast food served from the heated trolley was not refreshed during the morning, and we observed that the quality of food offered to people choosing to eat later deteriorated. Staff informed us they could request fresh food but this did not happen spontaneously and required the intervention of inspection staff to prompt this.

We observed staff supporting people to eat and drink, and this was usually undertaken with care and compassion. On most occasions we heard and observed staff asking people if they would like gravy, condiments, or help cutting up their food. However we did also observe some occasions when people did not receive the help they needed to eat, or to cut their food into manageable pieces.

People living at Heath House had a complex range of health needs, relating to their physical, emotional and mental well-being. A greater proportion of the people we met during the inspection had been supported to undertake their personal hygiene to a good standard, however we still observed some people wearing dirty and ill-fitting clothes, not all of the men living at the home had been supported to shave regularly, people had not all been given the opportunity to brush their hair, cut and clean their nails or to wash their hands and face. Care plans we reviewed recorded that it was the person's wish to be supported regularly with their personal care. Only one person we spoke with was able to tell us when they were last offered a bath or shower, they said this was about once a week, although they wished it was more often. Staff we spoke with told us it was not always possible to support people to the extent required due to the demands on staff and some people's reluctance to undertake personal care. Despite some people's reluctance and anxiety around personal care there were no specific risk assessments or written strategies to support staff care for people who may be reluctant to attend to their personal care. Some staff we spoke with had strategies for supporting people. Other staff told us they did not know what they would do, and one member of staff said, "I have never been in an aggressive situation. I don't really know what I would do." We looked at records of personal care for three people. These all showed that people received a daily wash but no regular access to a bath, shower or hair wash. For one person records went back to 40 days, and there was no hair wash offered in this period. For another person records went back 47 days and there was no bath or shower offered or recorded in this period.

Three of the five people whose care we looked at in detail had needs relating to pressure area care. [Developing sore skin if you sit or lie in the same position for too long.] Staff informed us that one person's pressure area care had improved and this information was supported by records that showed existing wounds had begun healing. While this was positive, records we looked at showed that the person had not been supported to change their position as often as good practice guidelines or the person's own care plan required. Another person was assessed as requiring their legs to be elevated to help maintain healthy skin. Over two days of the inspection the person never had their legs elevated. Staff did not offer this to the person. We were informed that the person was unlikely to agree to this intervention. The person's reluctance to sit in this position was not mentioned in the care plan, and it was not evident that any alternatives or compromises had been explored with the person.

One person whose care we looked at in detail was experiencing a change in their mental wellbeing. Nursing staff had completed a risk assessment, the score of which suggested the person was depressed. The GP had prescribed medicine to reflect this. The date the medicine was started was recorded differently on different documents we viewed. The manufacturer advised the medicine could take up to two weeks to become effective,

Is the service effective?

so knowing the date a person started taking the medicine was important for nurses who needed to monitor for signs of improvement in the person. Records for the person stated "history of suicide." Staff we spoke with had no knowledge of this, or of the current risk this might present as the person was now assessed as being depressed. Records and our observations showed that the two hourly wellbeing checks detailed in the person's care plans were not being undertaken or recorded with the agreed frequency.

We looked at the support offered to three people, who were assessed at risk of constipation. For each person the care plan contained a clear instruction that the nurse in charge at the time should be informed if the person did not have their bowels open for a certain number of days. In all three cases we saw occasions when the agreed number of days had been exceeded by between three and five days. There was no evidence that the nurse in charge had been made aware of the person's condition, that medical advice had been sought or adjustments made to the person's medicines, food or fluids to encourage a bowel movement. Not going to the toilet regularly can cause people extreme discomfort and can have negative effects on people's appetite, mood and behaviour. Failing to provide the care and treatment that people request or have been assessed as requiring is a breach of the Health and Social Care Act 2008. Regulation 12.

We observed people wearing glasses and hearing aids, although most people had not been supported to clean their glasses to ensure they could see clearly. Two people confirmed they were able to see health care staff, and during our inspection we observed health professionals visiting people. One visiting professional told us they were supported by staff to ensure they could help people achieve good eye health. Records showed that health care appointments had been made or requested where these were due.

Our observations identified that some people were being deprived of their liberty and the manager was able to demonstrate that this had already been identified and that applications had been made to the local authority regarding these deprivations. Staff we spoke with about the Mental Capacity Act 2005 and the impact it had on their work had a basic understanding of this and how it applied to their role. We looked at the records for two people concerning their ability to make decisions and their mental capacity. The documentation had not been fully completed for either person and did not provide clear information or guidance about the support each person required to decision make concerning significant issues they may face. There were no formal capacity assessments, nor any assessment of the person's cognitive ability which would help staff recognise or respond to future changes in the person's wellbeing. During our inspection we observed staff seeking people's consent before commencing an activity or intervention with them. The care plans we observed had not been signed or agreed by people using the service. We saw a letter inviting relatives to meetings about the care of their loved one, and this offered relatives the opportunity to "sign consents." We saw no evidence that the relatives had the appropriate authority to sign the documents.

The people living at Heath House had a wide range of needs and we looked at the training provided to ensure staff had the knowledge they required to meet these needs and to work safely. The manager had undertaken a review of people's training needs and we saw that each staff member had received a letter informing them of the training they needed to undertake. We looked at the induction and support given to one new member of staff who had been in post for six weeks. During our inspection we observed the member of staff working without direct supervision, both the person and the recruitment records confirmed they had not worked in a care setting before. The member of staff had not been provided with training in subjects relevant to their work such as safeguarding or working with people who were living with dementia.

Requires improvement

Is the service caring?

Our findings

We last inspected this service in April 2015. At that time people were not receiving compassionate care and support. We told Four Seasons Health Care that the service they were providing was inadequate and we commenced enforcement action to ensure that legal regulations would be met and changes made to ensure that people living at Heath House would receive the care and support they needed with kindness and compassion. We returned to inspect Heath House in September 2015 and found that some improvements had been made. On some occasions and in some circumstances people were receiving a caring service but these improvements were not consistent.

People told us that the staff were mostly kind and shared examples of times they had been treated with dignity and respect; however people and staff we spoke with also shared some examples when this had not been the case. We observed one gentleman being asked to speak English, despite this not being his first language. Staff repeatedly said, "Speak English. Speak English." There was no evidence of alternative communication in the person's preferred language being explored. Another person explained how they often had to wait a long time to go to the toilet which had resulted in them being incontinent. We observed and overheard some examples of inappropriate conversations including a discussion across the dining room and then across the staff team of both units when someone requested support with going to the toilet part way through a meal.

We observed and overheard many positive interactions between staff and the people they were supporting, and many of the staff had started to use phrases such as, "Can I help you?" and "Can I give you a hand?" This showed staff were considering ways to promote people's independence and gain people's consent before supporting them with an activity or intervention. Two people told us, "They treat me with respect", and "They're okay. I like [name of staff] they are kind to me." A member of staff we spoke with shared examples of how people were now being treated with more dignity and they told us, "Residents are much safer and are treated with much more dignity and respect." During the inspection we observed two incidents where staff were injured by the people they were supporting. We observed that staff maintained a friendly and calm conversation with people while trying to resolve and calm down the person's anxiety.

We observed that a greater number of people had been offered the support they needed to complete their personal hygiene and to wear clothes that fitted them well and were clean. We did however still observe people who were not clean and fresh and people who were wearing clothes that were ill fitting. One gentleman wore trousers that kept slipping down. Staff often walked past him, or commented on the trousers; however no one assisted him to change the trousers or to add a belt. One lady seated in a wheelchair had her back and stomach on display as the top of her clothes had not been pulled down when she was supported to dress.

Staff we met communicated with people effectively and with compassion. We observed staff enhancing the way they communicated by using touch, bending down to make eye contact with people and altering the tone and volume of their voice. We observed the support given to a person who was being cared for in bed. The staff involved showed care and compassion and explained and reassured their actions to the person throughout. Staff ensured the curtains of the ground floor bedroom were closed to maintain the person's privacy. Relatives we spoke with told us, "The staff are all lovely" and "The staff are all very caring. I'm happy with the care he gets."

We were informed by the Deputy Manager that one person was receiving end of life care. Staff described how the person's needs and wellbeing varied on a day-to-day basis. The care records shown to us did not contain an end of life care plan that reflected the person's wishes or that was in line with published good practice guidance about end of life care.

Requires improvement

Is the service responsive?

Our findings

We last inspected this service in April 2015. At that time people were not receiving a responsive service. We told Four Seasons Health Care that the service they were providing required improvement and we commenced enforcement action to ensure that legal regulations would be met and changes made to ensure that people living at Heath House would receive the care and support they needed. We returned to inspect Heath House in September 2015 and found that some improvements had been made. These improvements were not consistent and did not benefit all of the people living at the home.

Staff we spoke with and observed had a detailed knowledge of the people they were supporting. Staff were able to tell us about important people in each person's life, some of their life history and things that would help them relax or that they might enjoy doing each day. Staff had gained this knowledge from working with people over time and getting to know them and their relatives. We found that this individual knowledge gained by staff was being supported by new home wide initiatives such as "Resident of the Day" and inviting people's relatives to meet with the new home manager to explore developing a memory box and ways of making each person's care more individual to them. The resident of the day programme had only started a few days before our inspection. Research shows that if used well this can be a way of helping staff understand more about each person, what is important to them and it can promote more personal and meaningful care. At the time of our inspection records we viewed and discussions with staff showed that this had not yet been fully understood or delivered, and that the care being delivered remained focussed on completing tasks.

A review of the activities and opportunities available for people had been undertaken. For some people this had resulted in an increase and improvement in the number and type of opportunities available to them. One person we spoke with was pleased to have been able to visit a local fast food restaurant. However many of the people living at Heath House were at risk of being socially isolated and we observed that throughout the inspection the majority of people were disengaged or asleep. People did not have the opportunity to participate in activities that were of interest to them, or which reflected the interests they had enjoyed in their earlier life. Staff had not been supported to develop the specialist skills required to engage with and provide meaningful opportunities for people living with advanced Dementia and ongoing mental ill health.

There were facilities to play music around the home. Sometimes this worked well and we could see people enjoyed this. We also heard CD's get stuck, and staff did not respond to this. Some CD's had a mixture of different genre's including Christmas music. This would not help people to orientate themselves to the season of the year. Professional guidance about supporting people living with Dementia states people should be supported in homely environments that aid orientation. The guidance suggests adaptations that can be made to the lighting, colour schemes, floor coverings, signage and garden design. Adaptations such as these were not evident at Heath House, and had not been incorporated into the redecoration of Walkers Unit which had been undertaken in June of this year. The home manager explained he was working with specialist staff to explore ways of improving the situation, but at the time of our inspection people did not all have opportunity for engagement or to pursue activities of interest to them.

The home manager showed us work undertaken to investigate, record and feedback on concerns brought to his attention. The records we viewed showed this work had been undertaken thoroughly and a detailed response provided. Relatives we spoke with told us they felt confident to raise concerns. They told us the new manager was easily available and easy to speak with. Relatives we spoke with said they would feel able to complain and one relative shared an example of doing this. They told us the response was quick and thorough and that they were happy with the outcome.

Inadequate

Is the service well-led?

Our findings

We last inspected this service in April 2015. At that time people were not benefitting from a well led service. We told Four Seasons Health Care that the service they were providing was inadequate and we commenced enforcement action to ensure that legal regulations would be met and changes made to benefit the people living at Heath House. We returned to inspect Heath House in September 2015 and found that some improvements had been made although these were not adequate and the improvements made were not being consistently applied.

We had previously raised concerns about the systems in place to ensure all staff had the information they needed to undertake care safely and in the way people have requested. The inspection identified numerous occasions when communication within the home had not been effective. Two staff described how they had come on duty and not been informed that a person had passed away. Staff described how they had gone to prepare the person's breakfast and medicines, before other staff informed them of the person's death. Staff we spoke with gave examples of changes that had occurred they did not know about, these included changes in people's eating and drinking needs and moving and handling needs." One staff member said, "I don't really know what we can or can't do. Better communication is needed." Other staff told us, "Verbal handover was very useful and informative. Now it is just nurses and seniors", "A communication book for handover would improve the staff knowledge about what has happened while we were on rest days" and "Sometimes things happen and you are not made aware of them when you come back on duty days."

During the inspection meetings were held with members of staff, relatives and people living at Heath House. This provided an opportunity for people to receive and exchange information. We observed two incidents when staff were injured while caring for people. Neither staff member chose to report the incident. We had received information from a whistle blower who described trying to raise concerns with the homes senior staff and manager and not being able to do this. This provided evidence that there was a lack of transparency and openness within the culture of the home.

We observed staff working differently to people's planned care. When we spoke with staff about this they were not aware of the changes in people's needs and the subsequent revised plan of care. There was no established system to share this information. Staff were not always given the information they required and that this had a negative impact on the day-to-day experience of people both living and working at Heath House. This was a breach of regulation 17 of the Health and Social Care Act 2008.

The registered provider had implemented a new care planning and recording tool across the organisation. Senior staff we spoke with were aware of the potential benefits of the new system but were not able to explain how they had used any change management or risk assessment tools to ensure the roll out of the new system was undertaken effectively and safely within this home. As we looked at records of care and spoke with staff it became apparent there was confusion about how to complete the records, we found numerous records running for the same person for the same time period and that some records had been removed or archived too early so that no record to underpin certain elements of people's current care were available. This would have a negative impact on the ability of staff to maintain the continuity, quality and safety of people's care. The registered provider had commissioned a transfer of care documents from one style of written records to a new one. We were concerned that many records were written as the person "will have" rather than showing any partnership or joint working. The registered provider had acknowledged the need to provide a service that was more reflective of people's individual needs and wishes, and had started work to transition to this style of care. Staff we spoke with and our observations showed that people were being supported in ways that were more individual and which reflected some of their religious and cultural needs that had previously been omitted.

The records available were not in good order and would not enable the nurse evaluating the person's care to determine the progress made towards each person's care or life goals. We looked at the ways senior staff and the registered provider were auditing and monitoring the roll out of the new system. We were shown some audits that had been completed, but there was no evidence to show that the shortfalls identified in the records had been brought to the attention of the nurse, or that the nurse had been given the time, support or training required to make the improvements needed.

Inadequate

Is the service well-led?

One person's care plan we looked at in detail stated how the person was to be supported to take their medicines in the event of them not agreeing to take them. This plan was contrary to information we had received in a discussion. When we asked further questions about this the nurse told us the information had been written in error and was not accurate. We found other examples of information being written or transferred incorrectly which could present a risk to the continuity or safety of people's care.

These findings showed that the systems to monitor the effectiveness of care were not adequate and this is a breach of regulation 17 of the Health and Social Care Act.

A new management team had been appointed to the home. Feedback from people living at the home, relatives, staff and visiting professionals was that this had already been positive and that changes in the atmosphere, culture and day-to-day running of the home had been noticed. We observed that staff were very busy, but that there was a sense of purpose and direction. We observed nurses and the senior carers providing leadership and direction when staff needed guidance, or when people required support. Comments we received included, "There is a better management and leadership structure than in the past", "The new management are making some steady changes" and "The new manager seems approachable."

Locations that are registered with the Care Quality Commission are required to have a registered manager in post. This service had been without a registered manager for 5 months. A new manager had been appointed and has made an application for registration. The provider had made arrangements to ensure that notifiable events which happened at the service were being reported which is a requirement of the law.

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements were not being met and we have taken enforcement action.

Regulated activity	Regulation
	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment People were not consistently supported to move safely. Medicines had not all been administered as prescribed or used in a way to be most effective. The registered provider had failed to consistently provide the care and treatment that people requested or had been assessed as requiring.

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

Regulated activity	Regulation
	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment The registered provider had failed to protect people from improper treatment.

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

Regulated activity	Regulation
	Regulation 18 HSCA (RA) Regulations 2014 Staffing The registered provider had not taken action to ensure that adequate numbers of staff would be available to meet people's needs.

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

Regulated activity	Regulation

This section is primarily information for the provider

Enforcement actions

Regulation 17 HSCA (RA) Regulations 2014 Good governance

The registered provider had failed to ensure adequate, effective systems of communication were in place within the home.

The systems to monitor the safety and effectiveness of care provided were not adequate

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

Regulated activity

Regulation

Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs

The registered provider had failed to ensure people had adequate food and fluids to maintain good nutrition and hydration.

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