Heartwell Care Ltd

# Heartwell House Residential Care Home

**Inspection report**

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Date of inspection visit: 21 September 2015
Date of publication: 02/12/2015

## Ratings

| | |
|---|---|
| Overall rating for this service | Inadequate |
| Is the service safe? | Inadequate |
| Is the service well-led? | Inadequate |

## Overall summary

This inspection took place on 21 September 2015 and was unannounced.

We previously carried out an unannounced inspection of this service on 21 May and 11 June 2015. Six breaches of legal requirements were found, two of which led to warning notices being issued, and the service was judged to be 'Inadequate' overall.

The warning notices were issued because the registered person did not have effective systems and processes in place to ensure people using the service were protected from abuse. Nor did they have an established system or process in place to enable them to assess, monitor and improve the quality and safety of the service provided in the carrying on of the regulated activity.

After this inspection we asked the provider to produce an action plan stating what they would do to meet legal requirements in relation to the breaches. We did not receive one. The provider said this was because he thought he had to share this information with the local authority and not CQC. He then agreed to send one retrospectively.

We undertook this focused inspection on the 21 September 2015 to check that the provider had now met legal requirements with regard to the warning notices. This report only covers our findings in relation to the warning notices. We will check the other breaches at a future inspection.

You can read the report from our last comprehensive inspection, by selecting 'all reports' link for Heartwell House on our website at www.cqc.org.uk

Focused inspections evaluate the quality and safety of particular aspects of care. They take place when we are

# Summary of findings

following up after a comprehensive inspection, or when we have received concerns and have decided to look into them without doing a comprehensive inspection of all aspects of the service. They only ask the relevant key questions, rather than all of them.

Heartwell House Residential Care Home provides care and support for up to 13 people with learning disabilities or mental health conditions. It is situated in a detached house in Leicester City. The home has two lounges and a dining room. There are 11 single bedrooms and one double bedroom situated on the first and second floors with stairs for access.

Heartwell House is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider. At the time of our inspection a registered manager was employed at the service.

Some care plans and risk assessments had been improved and others put in place to provide staff with the information they needed to protect people from harm. There was now a stronger emphasis in records on managing risks to people. However other care plans and risk assessments were still in need of improvement.

The staff members we spoke with were clearer about their safeguarding responsibilities. Safeguarding had been discussed with the people using the service and they had been told what to do if they needed to report abuse, or if they had reported abuse to staff at the home and nothing had been done.

Improvements had been made to way staff were recruited to help ensure they were safe to work in a care environment. During the inspection we observed there were enough staff on duty to meet people's needs.

The provider's undated quality assurance policy had not been followed and a system of quality assurance was still not in place.

We found some evidence of people using the service and relatives being asked for their views on the service. People had been given the opportunity to speak out at meetings and had had the service's complaints procedure explained to them. Quality assurance questionnaires had been sent to relatives and returned, although at the time of our inspection no analysis had been made of the results of this survey and no action taken in response.

We found that the warning notices had been partially met and as a result we have used requirements notices to address the outstanding breaches. 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?**

Inadequate 

The service was not consistently safe.

Some people's risk assessments were still in need of improvement.

Staff had had further training in safeguarding.

Staff recruitment procedures had improved to help ensure staff were safely recruited.

There were enough staff on duty to meet people's needs.

We could not improve the rating for 'Safe' from 'Inadequate' because to do so requires consistent good practice over time. We will check this during our next planned Comprehensive inspection.

**Is the service well-led?**

Inadequate 

The service was not consistently well-led.

There was still no established system or process in place to enable the provider to assess, monitor and improve the quality and safety of the service.

The people who used the service had more opportunities to share their views on it.

We could not improve the rating for 'Safe' from 'Inadequate' because to do so requires consistent good practice over time. We will check this during our next planned Comprehensive inspection.

# Heartwell House Residential 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 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 focused inspection took place on 21 September 2015 and was unannounced. Focused inspections evaluate the quality and safety of particular aspects of care. They take place when we are following up after a comprehensive inspection, or when we have received concerns and have decided to look into them without doing a comprehensive inspection of all aspects of the service. They only ask the relevant key questions, rather than all of them.

The inspection was undertaken by two inspectors and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. Our expert for this inspection had experience of the care of people with learning disabilities.

We used a variety of methods to inspect the service. We spoke with five people using the service, one relative, the provider (who is also the registered manager for the home), the deputy manager, and three care workers.

Due to communication difficulties not all the people using the service were able to share their views with us so we spent time with them and observed them being supported in the lounge and dining area.

We looked at records relating to the safety of the people using the service, and the management of the service. We also looked in detail at four people's care records. Prior to the inspection we also spoke with staff from the local authority who contracts with this service.

Inadequate

# Is the service safe?

## Our findings

On 15 July 2015 we issued a Warning Notice to the provider due to their failure to comply with Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safeguarding service users from abuse and improper treatment.

This was because the registered person did not have effective systems and processes in place to ensure people using the service were protected from abuse, some staff did not understand their safeguarding responsibilities, the provider's safeguarding and whistleblowing polices were not fit for purpose, and people's risk assessments did not always contain the information staff needed to keep people safe.

The provider's action plan stated that staff had been re-trained in safeguarding awareness, and that safeguarding was to be discussed with staff in meetings and supervision to ensure they understood their responsibilities. However this action plan did not address the concerns in our report regarding the quality of the safeguarding and whistleblowing polices, or people's risk assessments.

At this inspection we found that this breach in regulation had only partially been met and consequently there was a continuing breach of Regulation 13.

We looked at people's risk assessments. The provider told us these had been re-written and improved.

We saw that some care plans and risk assessments had been improved and others put in place to provide staff with the information they needed to protect people from harm. There was now a stronger emphasis in records on managing risks to people. For example, care plans and risk assessments now provided staff with information on signs and symptoms associated with people's diagnosis of mental health, such as visual or auditory hallucinations, and possible staff responses to behaviours that may challenge. Risk with regard to people's physical health had also been addressed. For example, there was good information in place for staff to monitor a person who had eating difficulties which meant staff the information they needed to keep this person safe with regard to their nutrition.

Other care plans and risk assessments were still in need of improvement. For example, one person's records highlighted the risk of inappropriate behaviour towards others. Staff were advised to be vigilant and intervene when necessary, but there were no instruction in place on how they should do this.

In another person's records we found incidents of behaviours that challenge recorded in daily logs where a person using the service had allegedly made threats. Staff had recorded that their intervention did not work and they had had to call the provider to assist them. Although this situation was addressed at the time there was no follow-up to it, for example the completion of an ABC chart (an observational tool that allows staff to record information about a particular behaviour with a view to better understanding what the behaviour is communicating), or a post-incident de-brief or review. This meant that staff did not have the opportunity to learn from this incident with a view to improving the way they managed behaviours that challenge in the future.

We also found that some people's risk assessments advised staff to offer a distressed or agitated person 'a cup of tea or a walk' as a way of de-escalating a potentially unsafe situation. We discussed this with the provider who said this response was used because it 'worked for everyone' in the home. However this did not take into account that at least one person did not always like to leave the home so the option of 'a walk' might not be suitable for them. Consequently we asked the provider to further review and improve risk assessments as necessary.

During the inspection one staff member was obstructive to a member of our inspection team when they asked to see a particular record. The staff member initially said he could produce the record the following day. We said we needed to see it that day so the staff member went and got it. When he returned and gave it to the member of the inspection team and said in a forceful tone, "Tell me are you happy now, tell me, tell me, are you happy with this!" This conversation took place in the sitting room while people using the service were present. We felt that this style of communication was not appropriate and could be intimidating to people using the service and the staff who work there. The provider told us that this staff member meant no harm in their approach. We acknowledged this might be the case but were of the view that some people might find it upsetting.

Inadequate

# Is the service safe?

Later on one person using the service told us the same member of staff had been unkind to him and told him, "It's so peaceful when you're not here." He said this member of staff also teased him about his clothing and social life. We reported this to the provider who said there was 'history' between this person and the member of staff and the person would try and get the member of staff in trouble. However he agreed to monitor the performance of the member of staff in question.

We spoke with three different staff members and all were clear about their safeguarding responsibilities. One staff member told us, "We report [safeguarding] to the local authority, we are not the investigators."

Records showed that since our last inspection staff had had further safeguarding training, safeguarding awareness had been discussed in staff supervision sessions, and at a staff meeting. One person, who was at risk of a particular type of abuse, had had their care plan and risk assessment updated and improved so it was clear to staff how to protect them.

Records also showed that safeguarding had also been discussed in detail with the people using the service at a residents meeting and on a one to one basis with people who were not at this meeting. People were asked if they understood what safeguarding meant and if they didn't this was explained to them. They were also taken to the noticeboard to see the contact number for the local authority should they need to report abuse, or if they had reported abuse to staff at the home and nothing had been done.

A local authority poster on the home's noticeboard gave staff and people using the service advice and information about what to do if they thought someone was being abused. The provider's safeguarding and whistleblowing had been updated although the contact telephone numbers for the local authority was wrong. This was corrected during the inspection.

One person told us, "The staff look after me well. Some staff have gone and new staff are coming in." This referred to the fact that three staff had left the home and three new staff were in the process of being recruited.

At our last inspection the provider had not obtained satisfactory evidence of staff conduct in previous related employment, where applicable. Nor had they obtained a full employment history, together with a satisfactory written explanation of any gaps in employment, from all staff employed by the service.

We checked the recruitment files of two recently recruited staff members. We found they contained the required information including proof of identity, criminal record clearance, satisfactory evidence of conduct in previous employment, and details of employment history. This meant the provider had taken the necessary steps to help ensure these staff were suitable to work in the home.

During the inspection we observed there were enough staff on duty to meet people's needs. We checked the staff rota which showed that the staffing levels on the day of our inspection were representative of the usual staffing levels.

We discussed night-time staffing with the provider to check there were enough staff on duty to meet people's needs. We also checked to see if staff of the right gender were available at night for one person using the service who may require them in an emergency. The provider told us that if staff of the required gender weren't on duty there was always one on call who could get to the home within five minutes. This meant the person in question's needs could be met in an emergency.

Inadequate

# Is the service well-led?

## Our findings

On 15 July 2015 we issued a Warning Notice to the provider due to their failure to comply with Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Good Governance.

This was because the registered person did not have an established system or process in place to enable them to assess, monitor and improve the quality and safety of the service provided in the carrying on of the regulated activity. The provider's action plan stated that systems were now in place to address this shortfall.

At this inspection we found that this breach in regulation had only partially been met and consequently there was a continuing breach of Regulation 17.

The provider's undated quality assurance policy had still not been followed. This stated that quarterly internal audits would be carried out in the following areas: catering, housekeeping, care, and administration. As at our last inspection, there was no evidence that quarterly audits had been completed or recorded.

However we did find some improvements to the service.

Regular checks on food hygiene, hot water temperatures, emergency lighting, and fire safety had been carried out and were dated with outcomes in logs books.

At our last inspection minutes of residents meetings did not contain any evidence of people using the service being asked for their views or being given the opportunity to raise any complaints or concerns. At this inspection we found that people had been given the opportunity to speak out at meetings. Records showed that staff had checked that people knew how to complain and how to contact the local authority if they wanted to report abuse. They were also asked for their views on food and activities in the home and had made suggestions which staff said they would follow up.

The provider told us that in August 2015 he had sent out seven quality assurance questionnaires to relatives and was in the process of collating the results. We looked at the responses and found that most people had rated the service 'good' or 'excellent'. One respondent had made a suggestion to improve the meals. The provider said this comment wasn't valid as it arose from a misunderstanding. At the time of our inspection no analysis had been made of the results of the survey and no action taken in response. The provider said the results would be analysed and action taken where necessary to improve the service.

We asked people if they had noticed any changes in the home since the last inspection. Most people said they did not know but one person told us, "There haven't been any changes since June [2015]."

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 | Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment<br><br>The registered person did not have effective systems and processes in place to ensure people using the service were protected from abuse. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA (RA) Regulations 2014 Good governance<br><br>registered person did not have an established system or process in place to enable them to assess, monitor and improve the quality and safety of the service provided in the carrying on of the regulated activity. |