Abbey Healthcare (Kendal) Limited

Heron Hill Care Home

Inspection report

Valley Drive
Esthwaite Avenue
Kendal
Cumbria
LA9 7SE

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06 December 2016

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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?	**Good**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This unannounced inspection of Heron Hill Care Home took place over two days on 5 and 6 of December 2016. We last inspected Heron Hill Care Home in July 2015.

At that inspection we found a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities Regulations) 2014 regarding the proper and safe management of medicines. We found that medicines were being not stored safely during medicines rounds and administration was not recorded correctly. We asked the provider to take action to make improvements. The registered provider gave us an action plan telling us how they were going to make the improvement by 31 October 2015.

There was also a breach of Regulation 9 (person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because records for the management of medicines and creams did not contain sufficient detail to make sure that people received appropriate care. At this inspection we found that this had improved. Some people were prescribed emollient creams that were applied by carers when they helped people wash and dress. We looked at seven people's records and found that carers were applying creams regularly

Heron Hill Care Home provides accommodation and nursing care for up to 86 people. The home is over three floors and has three separate units and each unit had separate dining and communal areas. On the ground floor, Nightingale unit provided general nursing care, on the first floor, Cavel unit provides nursing care for people living with dementia and on the second floor is McKenzie an all male unit.

There is a hairdressing room in the home. All bedrooms in the home are for single occupancy and have ensuite facilities. The service provides support to adults who have a physical disability, mental health needs, behaviour support needs, dementia and complex nursing needs. One unit is a 20 bedded all male unit, for those who may present different or more challenging behaviours At the time of the inspection there were 78 people living in the home.

At this inspection 5 and 6 December 2016, we found that some improvements had been made to aspects of medicines management. However, the medicine storage and medicines monitoring that could have an impact on people living in the home continued to require improvement. This was a continued breach of Regulation 12 (safe care and treatment) of The Health and Social Care Act 2008 (Regulated Activities Regulations) 2014.

We found there were several other breaches of the regulations that could have an impact on the people who lived there. There was a breach of Regulation 15 regarding premises and equipment, a breach or Regulation 11 - Need for consent and of Regulation13 - safeguarding service users from abuse and improper treatment. There was a breach of Regulation 18 - Staffing, Regulation 9 - person centred care and Regulation 17 - Good Governance.

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by CQC. The purpose of special measures is to:

Ensure that providers found to be providing inadequate care significantly improve
Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.
Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains 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 the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will 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 we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

At the time of this inspection the service did not have a registered manager in post. The previous registered manager had left the month before. 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.

We saw that the staff on duty approached people in a friendly and informal way. People told us that the staff were "kind" and "lovely". Relatives we spoke with during the inspection whose family members lived at Heron Hill Nursing Home told us they felt that the staff were caring and that they treated their family members with dignity and respect.

We found that a range of information and leaflets were available for people in the home and their relatives to help inform their choices. This included information about support agencies such as Age Concern, financial help and advocacy services that people could use. An advocate is a person who is independent of the home and who can come into the home to support a person to share their views and wishes if they want or need this.

We saw that care plans were being reviewed and updated. For example, changes in a person's weight or their continence needs that needed to be followed up with other agencies. Care plans we looked at contained nutritional assessments and saw a check was being done on people's weight to monitor for changes. People told us the food in the home was "good" and that they had a choice of food and drinks. We saw that if someone found it difficult to eat or swallow advice had been sought from the dietician or the speech and language therapist (SALT).

Some care plans that had not been completed with information on specific risks and behaviours. We have made a recommendation that the service seek guidance about developing with people a personalised care management plan so staff can take a person centred approach to care provision. We found that there were opportunities for people to participate in organised activities in the home but this was not always being effectively tailored to specific needs.

The home had systems to check information when new staff were recruited and all staff had appropriate background checks before starting work to help make sure they were suitable for the role. Training was being provided to staff on the safeguarding of adults who may be vulnerable due to their condition.

We noted during the inspection that contractual arrangements were in place for staff. These included disciplinary procedures to support the organisation in taking immediate action against staff in the event of any misconduct or failure to follow company policies and procedures. We could see that the deputy manager had been contacting staff to give them timescales in which to do the e learning and had issued internal 'improvement notices.

The service used a dependency tool to help them assess staffing needs against the level of need and dependency of the people living there. We noted that the dependency assessments did not present as being consistent in staffing for identified levels of need around the nursing staff. This was because there were not sufficient permanent registered nurses to increase numbers across all shifts should needs change and more nurses be needed quickly. There was no indication of contingency planning for cover on the units should these core nursing staff be off sick or on leave. We have made a recommendation that the registered provider reviews the staffing to make sure they can respond to nursing staff shortages and make sure they can respond quickly to changing nursing needs.

We observed that there was a complaints procedure displayed throughout the home for reference and information. We saw that resident and relatives meetings had taken place. These were used to share news and information within the home and to get people's views and ideas that might improve the quality and safety of the service. Relatives and people who lived in the home said that their views about the service were being sought.

You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not always safe.

The management of medicines in the home did not fully protect people against the risks associated with use and management of medicines.

The registered provider had not done all that was reasonably practicable to assess and mitigate the risks to people.

The registered provider had not ensured that the environment facilitated the prevention and control of infections in line with current legislation and guidance.

Aspects of maintenance and faults were not being dealt with in a timely manner to keep the environment safe.

Staff had been recruited safely with relevant checks in place.

Is the service effective?

Inadequate

The service was not effective.

Staff were not being given all the training, learning and development required to make sure they could consistently and safely fulfil all the requirements of their roles.

The environment for people living with dementia was not being developed to make it as supportive and enabling as possible for them.

The registered provider was not always acting in accordance with the requirements of the MCA 2005 and associated code of practice. This had led to abusive practises around unlawful restraint.

All of the care plans we looked at contained a nutritional assessment and a regular check was being made on people's weight for any changes.

Is the service caring?

Good

The service was caring.

The environment for people living with dementia was not being developed to make it as supportive and enabling as possible for them.

The service was caring.

People told us that they felt they were being well cared for.

People's privacy was being promoted and we saw that where staff engaged with people it was friendly and polite. People were able to see personal and professional visitors in private

We found that a range of information and leaflets were available for people in the home and their relatives to help inform their choices

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care and management plans were not always being completed promptly and some amendments to plans had not been signed and dated by the staff making them.

Support was provided so people could follow their own faiths and to maintain relationships with friends and relatives.

There was a system in place to receive and handle complaints.

Is the service well-led?

Requires Improvement

The service was not being well led.

There was no registered manager in post at the time of the inspection.

The implementation of the quality assurance systems had not been consistently effective in identifying and addressing all shortfalls in procedure and risks in the service.

People who lived in the home were asked for their views on how they wanted their home to be run.

Heron Hill Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider 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.

We visited the home on 5 and 6 December 2016. Our inspection was unannounced and the inspection team consisted of three Adult Social Care Inspectors, an expert by experience (ExE) and a pharmacist inspector. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

During our inspection we spoke with 14 people who lived in the home, nine relatives/visitors, five registered nurses, seven care staff, four ancillary staff, including domestic, two maintenance staff, and one member of the activities staff. We spoke with three visiting health care professionals, the interim manager, the regional manager, the deputy manager and the three unit managers. We spoke with people in communal areas and in private in their bedrooms.

We observed care interactions in the communal lounges and at mealtimes in the dining areas. We observed the interaction of staff with people living in the home and when care and support was being provided to people. We looked in detail at the care plans and records for 13 people and tracked their care.

We looked at records, medicines and care plans relating to the use of medicines in detail for people living on each unit in the home. We observed medicines being handled and discussed medicines with staff involved in their administration.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. It is useful to help us assess the quality of interactions between people who use a service and the staff who support them.

Before our inspection we reviewed the information we held about the service, including information we had asked the registered provider to send to us. We also contacted local commissioners of the services provided

by Heron Hill to obtain their views of the home. We looked at records that related to how the home was being managed.

We looked at the information we held about notifications sent to us about incidents affecting the service and people living there. We looked at the information we held on safeguarding referrals that had been made and applications the manager had made under deprivation of liberty safeguards. We looked at information sent to us by health care professionals involved in providing care and support to the people living there to get their views on service provision.

Inadequate

Is the service safe?

Our findings

We spoke with people living in the home and with relatives who were visiting. We received comments about the service that indicated a range of experiences. Three of the people we spoke with who lived at Heron Hill Care Home told us, "I feel very comfortable here" and " I've never seen anything that I found disturbing, they look after me extremely well" and also, "Not seen anything that concerns me". There were two relatives we spoke with who told us they felt their family members were safe living there. One said, "Oh, yes, I feel they are definitely safe here – given their health problems". Another relative said, "Yes, I feel they are quite safe here".

Other relatives had some concerns and told us, "We are a little concerned as other residents keep trying the door handle [to their room] and coming in". Two other relatives told us that some people wandered into their relative's bedrooms and said they were, "Constantly having to walk them back again". Another relative said, "It all comes back to staffing…sometimes [relative] continence pad might seem wet, I know the staff are rushed off their feet….when you ask them to do anything they do respond fairly quickly".

At our last inspection in July 2015, we found there was a breach of Regulation 12, Safe care and treatment, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because appropriate arrangements were not in place to ensure the proper and safe management of medicines within the home.

At this inspection we saw that a copy of the provider's medicine policy was available for staff to read but there was no indication as to when the policy was due for review. This meant that guidance in the policy could be out of date. We found that medicines were being kept securely but temperatures inside medicine storage rooms were above the maximum recommended by drug manufacturers. The home's records also showed that medicines that needed to be stored in refrigerators had not been kept at the right temperature. Medicines can become less effective or even harmful if they are kept at the wrong temperature. The staff could not be certain that the medication had not been rendered less effective and so it should not have been in use.

We watched one of the nurses give people their medicines at lunchtime. We saw that medicines were administered safely and those due at a specific time were given on time. We looked at the medication administration records belonging to a third of the people living in the home. We found three missing signatures but saw that the medicines had been taken from their pack, implying that the dose had been given.

One person was prescribed an antibiotic in liquid form. This medicine had not consistently been given correctly as the total amount recorded as administered on the medicines administration record (MAR) was more than the pharmacy had originally supplied to the home. There were also four doses of medicine left in the bottle. This meant the person had not received the right prescribed treatment for their infection. This had not been noted by staff when the medicine had been checked or administered.

We observed that a person was receiving medicines prescribed 'as required' for a particular reason. The records showed that it was being administered on a regular basis although the doctor's instruction was that it should only be administered 'as required'. There was no record to show the person's doctor had been informed of the person's increased need for the medicine or asked to review them.

At this inspection 5 December 2016 we found this was a continued breach of Regulation 12, Safe care and treatment, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because appropriate arrangements were not in place to ensure the proper and safe storage and management of medicines within the home.

We looked at how the service was assessing and managing risk within the home. The home used profiling beds and we found that bedrails were in use to reduce the risk of falls but their use was not being safely managed. We saw as we went around the home that bumpers or padded covers to prevent injury and reduce the risk of entrapment were not always being used when the bedrails were up and people were in bed. Bed rails are 'medical devices' and when used the registered provider must ensure that this is done so correctly. Risk assessments we saw for the use of bedrails stated that bumpers were to be used when the rails were in use and that they were being kept in the person's room when the rails were down. We found this was not the case. We raised this immediately with the deputy and regional manager so they could begin to address this straight away to make sure bumpers could be found to help keep people safe.

We looked at care plans to see how people were assessed by the service before and on admission to make sure they could meet that person's needs and mitigate any risks. People's care records showed that not all individual risks were being assessed and considered. We found that some pre admission assessments had not taken into account known risks. One person's admission assessments on Cavel unit did not reflect the risks of certain behaviours they had displayed previously that might put the person and others at risk. Therefore plans had not been put in place to mitigate the risk.

On McKenzie male only unit we saw that a psychiatric assessment that indicated when a person became agitated they could be a risk to others and particularly to females. There was no risk assessment for this person regarding their coming into contact with females. This risk had been identified in the hospital discharge plan by the care coordinator and the psychiatrist but not assessed by the service as a risk. The unit manager told us an assessment was not needed, as the person was "more compliant now with females" However, we observed this person displaying behaviours towards female staff members that would indicate that this was not the case. However, there was no risk assessment around their disinhibited and inappropriate behaviours around females to protect the person and others.

These matters indicated a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014- Safe care and treatment. . It was also a breach under Regulation 12 because the registered provider had not done all that was reasonably practicable to assess and mitigate the risks to people living in the home.

On 30 November 2016, five days before our inspection, a multi-disciplinary Contract, Quality and Patient Safety visit had been conducted. This had been an unannounced visit and a report and recommendations had been drafted and given to the home to implement. Seven recommendations had been made regarding aspects of hygiene, cleaning and their monitoring across different areas of the home that required attention from the registered provider. These recommendations will be monitored by the infection prevention lead from the Clinical commissioning Group (CCG) against the action plan the service is required to produce and work with to improve infection control and prevention within the home.

The Department of Health code of practice and guidance about the prevention and control of infections, 'Health and Social Care Act 2008: Code of Practice for health and adult social care on the prevention and control of infections and related guidance'. By following the code, registered providers can show how they have met regulations. Registered providers must comply with this guidance and make sure they provide and maintain a clean and appropriate environment that facilitates the prevention and control of infections [Criterion 2 of the code of practice]. The findings of the visit by the infection prevention lead indicated that the guidance was not being followed.

We saw that the profiling beds in use were due for servicing under the manufacturer's instructions by the end of 2016 This was not included in the home's annual maintenance plan for maintenance personnel to implement. We asked the regional and deputy manager about this and they told us it would be done before the end of the year. In addition, we found when we came to the home early in the morning that some external wall lights were not working. Maintenance evidence indicated this had been the case since January 2016. The regional and deputy manager said that this would be addressed that week. Whilst we were in the laundry, we noted that one of the tumble driers was not working and so the laundry staff had only one drier they could use. We found that the drier had broken in October 2015 and had not yet been replaced. Laundry staff told us they were getting a new one but could not say when that would be.

We noted that other aspects of maintenance had not been attended to in a timely manner to make sure all the systems in the home were safe and fit for purpose. Maintenance records indicated that one of the three boilers in the home had been switched off since May 2016 as it was not working properly but had not been repaired or replaced. There were two boilers in operation and the maintenance staff confirmed to us that consequently heating had been affected in some rooms. The maintenance staff's records were able to confirm that it had previously been raised with management. We asked the regional and deputy manager about this and they told us that this boiler was due to be repaired that week. We have since received information from the provider that the repair was carried out.

We noted that slings used with hoists for moving and handling were being used communally by the people living there rather that each person having their own individual sling. Slings are classed as a medical device but it was not easy to identify individual people's slings to make sure they were not being shared. Sharing these devices increases the risk to people of cross infection occurring.

This indicated were a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 – Premises and equipment. This was because the registered provider had not ensured that the environment facilitated the prevention and control of infections in line with current legislation and guidance. It was also because maintenance was not being planned and faults dealt with in a timely manner to keep the environment safe.

At our previous inspection in July 2015 we had found there was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because there was not a clear administration plan and record covering the use of the creams in a person's treatment. At this inspection we found that this had improved. Some people were prescribed emollient creams that were applied by carers when they helped people wash and dress. We looked at seven people's records and found that carers were applying creams regularly. This indicated that people's skin was cared for properly.

We noted that improvements had been made in other aspects of medicines management that we had identified as concerning at our last inspection. Protocols (extra written guidelines) were now in place for people prescribed a medicine 'when required'. This meant staff knew how and when to give these medicines. Some people were prescribed a medicine 'when required' to help them stay calm. We looked at

two people's records in more detail and found they were only given this medicine when they really needed it. Some people were given their medicines covertly (disguised in food or drink). The pharmacist had provided advice on how to give these medicines without reducing their effectiveness.

Medicines that were controlled drugs (medicines subject to tighter controls because they are liable to misuse) were stored and recorded in the right way. We checked a sample of three controlled drugs on each floor of the home and found that stock balances were correct.

Relatives on Cavel unit commented to us, during the inspection, about staff availability when people needed them. One told us "One time I was very concerned as a resident fell out of their wheelchair and I had to go find a member of staff to tell them". Another relative said, "When I see them hoisting other residents there are always two staff and they stand until the other person comes". They went on to say, "Some cases there are three staff to help one resident, as they are very heavy".

A person living there told us, "They [staff] are normally short at meal times upstairs and they go and feed the people in their rooms." Another said, "There is usually a bit of a wait at lunchtime, waiting on staff to take you back to your room".

Two relatives we spoke with on the unit said, "Since they filled up, the staffing is sparse again, you need at least another two or three staff, it's the same with when you want one, as they are hoisting or moving someone, then up to three staff are tied up." One relative said; "There is not enough staff, but lately it has improved, I think it feels like there is more staff around."

We made an early visit to the home so we could speak with night staff. We found 19 people were living on the second floor all male unit [McKenzie]. During the night there had been a registered general nurse (RGN) on duty with two health care assistants (HCA). There was a registered general nurse (RGN) on duty during the day, who was the unit manager, and four healthcare assistants supporting them. The men living on McKenzie unit had a range of care needs and behaviours. No one living on the unit was subject to close observation or one to one support when we inspected, although one person was to be kept in sight. We noted during the inspection that person was exhibiting behaviour that challenged staff.

On Cavel unit there were 33 people living with dementia. Overnight there had been a registered nurse and two health care assistants on duty. There should have been three care assistants on duty but one person had gone sick at short notice and an agency carer was not available. There were two registered nurses on duty during the day and six healthcare assistants. Dependency levels were high for 18 people living there who needed at least two staff to assist them with their moving and handling needs. Two people were being checked at 30 minute intervals and one at 20 minute intervals. The rotas showed that usually there was one nurse on duty throughout the day. However, there were two permanent nurses working on the unit when we inspected. Rotas indicated that these were the only two permanent nursing staff on the unit and we could see that they did extra shifts on a regular basis to cover shortfalls, such as holidays and sickness.

On the ground floor general nursing unit [Nightingale] there were 26 people. During the day there were two RGNs on duty; one was the unit manager and six health care assistants. Rotas showed that some days there were two nurses and some days just one. There was a core of two permanent qualified nursing staff on the rota around which the nurse rotas were based. As with Cavel, this gave consistency when they were on duty but there was no indication of contingency planning for cover on the units should these core nursing staff be off sick or on leave.

On the first day of the inspection we found adequate levels of staffing to meet people's physical needs. The

service used a dependency tool to help them assess staffing needs against the level of need and dependency of the people living there. We noted that the dependency assessments did not present as being consistent in staffing for identified needs around the nursing staff as there were not sufficient permanent registered nurses to increase numbers across all shifts should needs change and more nurses be needed. There was no indication of contingency planning for cover on the units should these core nursing staff be off sick or on leave.

The registered provider was continuing to try to recruit permanent staff. We also noted that rotas did not always have the full names of the staff on duty and the capacity in which they worked, such as agency or permanent staff so they could be identified. We recommend that the registered provider reviews the staffing to make sure they can respond to nursing staff shortages and make sure they can respond quickly to changing nursing needs.

We found that systems were in place to help make sure people living there were protected from abuse and avoidable harm. The nursing and care staff we spoke with could tell us of what may constitute abuse and that it should be reported to their managers for referral to the local authority.

During this inspection we looked at nine recruitment records for staff employed since our last inspection. We saw that all the checks and information required by law had been obtained before the staff were offered employment in the home. Checks were made to ensure that registered nurses were registered with their professional body and fit to practice.

Inadequate

Is the service effective?

Our findings

The people we spoke with who lived at Heron Hill Care Home and their relatives told us they thought staff were trained to be able to meet their needs or their family member's needs. One person said, "They seem to know what they're doing." A relative said, "I think the staff are very competent and knowledgeable about them [relative], they phoned me once, when the GP came just to update me." Another relative told us, Yes, staff are very confident in their skills. My [family member] had a swollen foot, and the staff rang me to let me know the GP had come out or sometimes if the out of hour's doctor has come and arranged for an x-ray."

At lunchtime, we observed the dining experience on the ground floor dining room, where twelve people were having their meals. We saw that there was a choice of food at mealtimes in the home and people were asked what they wanted. We asked some people living there if they could order something instead or ask for something to eat other than at mealtimes. We were told, "I don't know, if I can do that" and "I think you have to eat at meal times."

There were no menus advertising what the choices would be on the day we inspected. We asked a staff member about menus and we were told menus were being printed. We received a range of comments about the food from the people who lived there including, "The food choice is good." and "I like the food very much." Whilst others told us "Its ok, it's just ok." and "The portions sizes are too big."

Three of the relatives we spoke with felt that the staff were aware of their family member's food likes and dislikes. One relative disagreed and said, "I have not been asked for their likes and dislikes." We asked relatives if they could sit with their family members during mealtimes, all relatives we spoke to agreed this was the case. We were told, "You can sit down with them at mealtimes or even come in and help them to eat, they are good like that" and "Quite happy for me to come at mealtimes, and I come every day to feed my [relative]".

One visiting relative said to us "I think there is a good choice of food, there is always a bowl of fresh fruit now, as it used to be mouldy and left on the side". Another relative who visited, brought in their own sandwiches at lunch time when they both sat together for lunch. Heron Hill Care Home used white bread and both of them are vegetarians and they like brown bread. We asked if they had asked for brown bread and they said they had and that it could be provided. They said they still preferred to bring their own sandwiches, as they had more choice than the ones being served in the home.

All of the care plans we looked at contained a nutritional assessment and a regular check on people's weight for changes. We saw that if someone found it difficult to eat or swallow advice was sought from the dietician or the speech and language therapist (SALT) and a plan developed from the advice given to support them.

CQC is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS) and the Mental Capacity Act 2005 (MCA).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 made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

On McKenzie unit we looked at care plans and found one person who refused personal care and who could be "verbally aggressive and threatening" and "sometimes refuses medication". A risk assessment was in place for self-neglect and the increased risk of infections. We looked for a management plan on how to manage these behaviours and found only basic information to leave the person if they became agitated and would not accept personal care and return when they had calmed. There was no plan with specific detail about how to communicate with the person or about how long that time should be or when other action should be taken regarding personal care or what that action should be.

We spoke with staff on duty about how this person's behaviours were being managed so they could be given personal care and their behaviours managed. They told us they were using some restraint to deliver personal care when the person refused it. There was no evidence in the care plans or risk assessments to show how the staff had come to use restraint. Behaviour monitoring charts did not refer to it and there were no records of a review of the management of the person's behaviour.

Staff told us that three staff members are needed to give aspects of personal care to this person and that one staff member "always holds his hands during personal care" but this was not stated anywhere in the care plans. The personal care plan did state that "Staff to use the holds" but does not say what these holds were.

We asked the unit manager the status of the application for a DoLs that had been made for this person and they were not sure if an urgent application had been made given the behaviours. The deputy manager was able to confirm that no urgent authorisation had been submitted. We asked that the correct application be made straight away to make sure this person's rights be protected. This was undertaken on the day of the inspection.

We saw that staff on the McKenzie unit had received recent training from an external body on 'Breakaways' and 'Holding skills – Control and Restraint'. The holding skills training had included four different holding techniques. However, there was no information in care management plans for staff to follow on what was authorised for use, why any technique should be used and how and when they should put training into practice. There is a clear difference between breakaway to equip staff to escape when they are being physically attacked and restricting a person's movement. Restraint should only ever be used as a last resort and alternative less restrictive methods should be clearly stated in the care plans and explored before using restraint.

We asked to see the care plan that stated when restraint could be used however there was no care plan that indicated exactly what restraint or holds were authorised or the level of intervention and what to do if this was not effective. There was no monitoring documentation for the holds used and no follow up on its use. The DoLs form applying to restrict this person's liberty had no reference to using restraint for personal care or to manage their behaviours or the use of covert medication. A care plan for the use of restraint was not in

place and therefore the other plans for how to manage specific behaviours were of no practical use and not fit for purpose. In addition, skin care and risk assessments, should the person refuse the application of creams, held no information about how this would be managed effectively or if restraint was sanctioned for this.

This person had a risk assessment in place for aggression towards others. The control measure in place was "Staff should try to be aware of [person's] position within the unit and intervene as necessary" but the plans did not state what the intervention should be except for basic information about using a "calm manner". We observed this person behaving inappropriately on two occasions but there was no monitoring of the person's whereabouts on the unit as indicated by the risk control measure. The services updated statement of purpose describes McKenzie unit as being for those "who may present different or more challenging behaviours". The assessment systems and behavioural management we observed on the unit were not consistently meeting those "challenging behaviours" effectively.

We also noted that in some cases relatives had signed to give permission for aspects of care in people's care plans and for photographs to be taken. For some of the people there was no evidence the relatives signing had the legal powers of attorney to give this consent. We saw that one person had a mental capacity assessment about their residency and about care delivery saying they did not have capacity to make decisions on this but no evidence of a best interest's discussion regarding this.
This was a breach of Regulation 11- Need for consent- of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the registered provider had not made sure that all the people using the service or those acting on their behalf had given lawful consent.This was also a breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the registered provider had not ensured the systems in place were effective to make sure people were always protected from improper treatment and that staff always worked within the requirements of the Mental Capacity Act 2005 and deprivation of liberty safeguards.

We looked at the training matrix and records in the home and noted that the service had a training programme and had used e learning for a significant number of the training topics. We saw in the training records provided to us that just over 70% of nursing and care staff had completed the moving and handling theory training but only 35% had done the practical training. In addition, whilst 74% of staff had done the fire awareness e- learning only 6.76% had received practical training. First aid training showed only 2.7% of staff had received that training. There was no evidence that staff's practical competence in these areas had been assessed following their e-learning to help ensure they were providing safe and effective care to people. The deputy manager told us that three fire training sessions were due to take place the following week for the night staff and that day staff had been identified to do Fire warden training.

Training records provided at the inspection were not up to date documents as we were shown certificates for fire training that had been done but the training matrix did not contain the information. We could not see evidence that a systematic and proactive approach had been taken to making sure all staff had received the training they needed for their roles or had been assessed as competent to carry out all their practical tasks. Training records need to be clear and up to date so people can be sure that there were suitably trained and skilled staff providing their care.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 - Staffing. This was because the registered provider had not made sure that all staff had received the training relevant to their roles and that they were competent to carry out the practical aspects of their roles.

The training matrix also showed that that in some areas a higher percentage of staff had completed their e learning such as in dementia care, equality and diversity, infection control and health and safety. We saw that registered nurses had done a six hour training session on clinical skills that included pressure area care, wound management, blood sugar level monitoring, taking blood and the use of equipment used at the end of life.

We saw during the inspection that contractual arrangements were in place for staff. These included disciplinary procedures to support the organisation in taking immediate action against staff in the event of any misconduct or failure to follow company policies and procedures. We could see that the deputy manager had been contacting staff to give them timescales to complete do the e learning and had issued internal 'improvement notices. We were told this action had resulted in some improvement in staff doing their e learning.

We observed as we went around the home that the environment for people living with dementia was not being developed to make it as supportive and enabling as possible for them. Signage was available to enable people to find their way to communal areas, however the service had not developed other environmental facilities for example memory boxes for people to fill with personal items can help them to navigate to their rooms, sensory items for people to engage with or coloured bathroom equipment to enable visual prompts for people living with cognitive impairment. We recommend that the registered provider seek advice and guidance from a reputable source so they adapt the home's environment so it reflects good practice to support the independence of the people who were living there with dementia.

Good

Is the service caring?

Our findings

We spoke with people living in the home about how they were cared for and how staff supported them to live as they wanted. People we spoke with made some positive comments about the staff that supported them. We were told, "Can't fault the care here, the staff are exceptional" and "The staff are lovely here" and also "The staff are very friendly…..they are helpful to me."

We asked relatives if the nursing and care staff were approachable and all those we spoke with agreed that they were. Their comments included, "All praise to the staff, even if I am upset they are very kind and give a cuddle and "When they see me coming there are always two cups of tea waiting in the dining room."

Relatives we spoke with during the inspection whose family members lived at Heron Hill Care Home told us they felt that the staff were caring and that they treated their family members with dignity and respect. One relative told us, "They address the people correctly, they are quite relaxed here". We were told that people's dignity was being upheld and a relative said, "They do respect [relative] dignity and they will change them in their room.

A relative told us that staff were "Very kind to people, my [relative] hasn't been very well and staff have sat with them holding their hands" and "They [relative] are well fed and well cared for". Another relative told us, "They [staff] always change them in their room and are quick to do this. I have never come in and seen them [relative] dirty. I do their washing and it is always bagged up waiting." Another relative commented, "I feel very comfortable here and happy now when I see them [staff] taking care of [relative]. It's given me more confidence as I was upset in the beginning to leave them."

Another relative commented, "Staff are quite kind here, some are very kind, more than half of them. Some can just do their job and then go home. A relative we asked told us, "Yes, they are caring; the staff seem to interact well with them and know how to cope with them. [Relative] has their favourites. Some staff seem better suited to care than others." One family we spoke to told us that they knew some staff did "Pop in to chat but others don't talk just give the care".

However one relative told us, "One of the staff is rough and ready but their heart is in the right place" and another that their family member who lived there had told them that at night "They [night staff] can be a bit brisk with them, unlike the day staff." We were told, "I had raised a concern …my [family member] did say the night staff were rough and brisk. I raised it and we are happy now that it was dealt with okay."

We saw that staff respected people's privacy was being respected. We observed that doors to bathrooms and toilets were kept closed when in use and bedroom doors closed whilst personal care was being given. We saw that staff protected people's privacy by knocking on doors to private rooms before entering.

We found that a range of information and leaflets were available for people in the home and their relatives to help inform their choices. This included information about the services offered, about support agencies

such as Age Concern and financial help and advocacy services that people could use. An advocate is a person who is independent of the home and who can come into the home to support a person to share their views and wishes if they want or need this.

All the bedrooms in the home were for single occupancy. This meant that people were able to spend time in private if they wished to. We spoke with some people in their bedrooms and saw these had been made personal places with people's own belongings, such as photographs and ornaments to help them to feel at home with their familiar and valued things. We were also told by people who lived there that they could have visitors when it suited them and see them where they wished.

Records indicated that a little over 62% of staff had completed training on supporting people at the end of life. Procedures were in place to support people at the end of their lives and to relieve any pain or distress. Appropriate equipment and end of life medicines were available to be used for people when this was needed.

Requires Improvement

Is the service responsive?

Our findings

We asked people who lived in the home if they were involved in their care plans and one person confirmed that they had been involved and that they had made "a joint decision with their partner" that they move into Heron Hill Care Home.

Two relatives we spoke with were not aware of any care plans being in place, whilst three others we asked were. One of these relatives said, "We were due for a care review in June then September, we ended up having it done in November. I have no concerns, nothing raised only odd things like not being shaved". Another relative told us, "I have not gone through a care plan as such, only informally at a care review." We were also told by a relative "I have not been able to go into detail about much medication or go through a care plan yet, they have only been here a week".

We saw that care plans were being updated to show where people's identified needs had changed so that staff were aware. For example, changes in a person's weight or continence needs that needed to be followed up with other agencies. We saw information had been added to plans of care as they were developed and as the persons, preferences and wishes became known. We noted that some amendments to plans had not been signed and dated by the staff making them. This meant it was not clear who had made the changes or when they had been made and this made accountability for decisions difficult to trace.

There were management plans in place to support specific conditions such as diabetes and tube feeding. However, we found less consistency in approach regarding how specific behaviours should be managed. This was not always made clear in individual's care plans. We looked at some care plans on Cavell and McKenzie unit that had not been completed with information on specific risks and behaviours. A person on Cavel, who had come to live at the home three weeks previously, had not had their care and management plans completed by staff and with them or their representatives.

This meant that care staff did not have all the information they needed to be aware of to develop an individualised plan and to address or mitigate any risks for that person. The approach was not person centred as people should have their care or treatment assessed promptly and personalised specifically for them with the actions staff needed to take. The plans need to be based upon a complete assessment of a person's needs and individual preferences.

A relative told us, "They [relative] could do with more activities, They're bored here, they can't watch television nor read a book. They just sit, eat, and sleep. Normally they [people living in the home] are just put in a circle in front of the TV." Another told us, "They [people who lived in the home] do need more activities as it is very quiet. They have music twice a week but I am not sure of the timetable". A relative did say of the activities, "There's not much… watching an old film on TV or listening to music usually or a singsong. They have used an old ration book to get them talking, also they have an old Cortina car book too".

We observed that there were people who were living with dementia sat in the lounges or due to their conditions were nursed in bed or did not leave their rooms often. We saw in care plans that consideration

had been given to their being at risk of social isolation. However, individualised activities plans were not being used to promote having one to one time from care or activities staff to reduce the risk of becoming isolated when spending long periods being nursed in bed. The care plans did not have individualised plans and record when time was being given and what was to be done to provide the most appropriate stimulation for that person.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 - person centred care. This is because the registered provider had not done everything reasonably practicable to make sure that the people who were using the service had all their needs assessed and so they received person centred care that reflected their physical, emotional and social needs.

We asked other people about what activities were available to them and how they spent their time. We were told that people could follow their own faith and attend a religious service. We were told, "It is the first Tuesday for Church of England." Another person said, "There is a chap who plays the piano and we sing along with them, there is dancing today at 4pm and we also do a spelling quiz. I can go to church here". We were told, "On the ground floor they have someone who comes in and sings. There is a comedy duo to watch and they come every fourth Tuesday". Another person who lived there told us "There is a quiz once a week, I enjoy it but there is not much else to do so I sit in my room reading".

Another relative on Cavel unit commented, "One of the staff members does do a lot with the activities; I have seen them come upstairs and they play games with one of the residents and brought books in for another. My relative has gone downstairs once or twice but is not able to do a lot now."

A relative spoke to us about their experiences of the laundry service in the home. They told us, "They don't iron in the laundry and one time one of their tops came back all creased and their laundry had been known to go missing before, even though I had put their name in everything. I take the laundry home now".

Another relative told us, "They [staff] lost a lot of their clothes… they were all named even the socks- just disappeared. Laundry comes back at 10.00pm, so it's the night staff that put it away and they don't know what they [relative] wear. I have gone back to the laundry to find some of their clothes still there. Even their memory foam pillow went missing".

The regional and deputy manager told us that they had discussed the laundry problems with relatives who had raised complaints and were implementing a new laundry system to help improve the service. We spoke with staff in the laundry and they told us about the new colour coded "button system". They told us that they found this a much better system for identifying people's clothing as previously labels had often come off. They told us the laundry staff would be putting clothing away rather than night staff to help make sure it went back to the right people and be put away properly.

The regional and deputy manager had responded to the concerns raised by people and highlighted in the questionnaires and had put new systems in place to try to improve matters. This indicated that they had listened to people's complaints and were prepared to respond to the need for changes. A person living there told us, "We got given a feedback form, it asked us about the laundry. "Another said, Filled one in last week [questionnaire], it was about the laundry but not made any difference yet."

We asked relatives if they knew how to make a complaint. One relative said, "Never had to make a formal complaint but I'm unsure of what the exact procedure is". Another told us, "I think so, I would find out if I needed to make a complaint". We observed that there was a complaints procedure displayed in the home for people to use for reference.

Requires Improvement

Is the service well-led?

Our findings

We observed that the deputy manager was very visible in the home. We observed him during the inspection on each floor talking to people living there and staff or saying hello to relatives. People who lived in the home told us "He usually pops up here to say hello" and "He always seems pleasant and approachable." Staff told us that the deputy manager was "very good" and that he "listened" and "took action". Relatives we spoke with commented, "The previous manager was not visible, just sat in their office" and "The deputy manager will pitch in and help out at breakfast" and "Since they [deputy manager] came there is fresh fruit on each table, instead of rotten fruit left in a bowl on one side."

The home did not have a registered manager in post as required by their registration with the Care Quality Commission (CQC). The registered manager had left the home in November 2016. At present, there was a temporary interim manager in post whilst recruitment was underway for a new registered manager. The home had a deputy manager who was providing support along with the regional manager.

The registered provider had a system in place for the registered manager to undertake quality checks across all the different departments in the service. These were quality checks or 'audits' to monitor all aspects of the service. We could see that some were going on and had highlighted issues in some areas. However, we found that the implementation of the quality assurance systems had not been consistently effective in identifying and addressing all shortfalls in quality, procedure and risks in the service.

For example, the monitoring of medicines requiring refrigeration. We found that nurses had carried out audits to check that medicines were stored in the right way. The home's own records showed that medicines in refrigerators had not been kept at the right temperature all the time. One audit we looked at recorded that the medicine fridge was working properly. The temperature checks indicated staff were aware of this but took no action to correct the situation. If audits are inaccurate, they will be ineffective in improving the safety of medicines handling in the home.

Training attendance was being monitored and the deputy manager was using internal communication systems to tell staff they needed to do specific e learning and that it was overdue. We could see that not all training was up to date so there was a flaw in the system if training was not always being done as required. We had also seen that maintenance matters were not always attended to promptly or planned for in advance to make sure they were done in good time.

Care plan reviews were not revealing there was insufficient detail in some of the plans especially around managing different behaviours and restraint. It had not been picked up that some care plans had not been completed or all risks to a person had not been assessed. Therefore the systems were not being wholly effective in identifying where aspects of the service were not performing to the required standard or identifying all risks.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 - Good Governance. This was because the monitoring systems being practiced were not being

consistent in identifying where improvements were needed in the quality and safety of the service and to be able to mitigate risks.

We could see that the management team in the home were using different methods to try to get people's views. We saw that resident and relatives meetings had taken place. These were used to share news and information about the progress of the home and to address any suggestions made that might improve the quality and safety of the service provision. .

Relatives and people who lived in the home confirmed that their views about the service were being asked. One person who lived there told us, "We got a questionnaire about four weeks ago, everyone got one. It was about the fresh fruit, the laundry, ironing and that sort of thing." A relative told us, "I do his washing so it didn't matter but the fresh fruit is now on the tables to help yourself to at any time rather than in one big bowl that was usually off." A visiting relative commented, "A questionnaire form was given to us to fill in but not had any feedback. They added, "I have seen a change here in the last six weeks". There were also 'residents and relatives' meetings where people could discuss issues in the home and give feedback to the management team.

We could see that laundry systems had been reviewed and changes being made to improve it. Cleaning audits had been implemented on a daily basis to check cleanliness. Daily allocation forms had been started on the units to be able to trace who was providing care to a person for accountability. The management team did checks each day on recording charts for fluid and positional change to help make sure these were completed by staff.

We were told by the regional manager that a new clinical lead was joining the home in January 2017 and they would have the main responsibility for monitoring systems.

We looked at the records of accidents and incidents that had occurred in the home on the units since our last inspection. We did this to check if action had been taken promptly following incidents and changes made if needed. We saw that incidents had been recorded and followed up formally with appropriate agencies or individuals where needed. The deputy manager had notified the CQC of any incidents and events as required by the regulations.

We spoke with the deputy manager of the home, the interim manager and the regional manager during the inspection. All were responsive to any issues raised and proposed courses of action to make necessary improvements.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care because the registered provider had not done everything reasonably practicable to make sure that the people who were using the service had all their needs assessed and so they received person centred care that reflected their physical, emotional and social needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent The registered provider had not made sure that all people using the service, and those acting on their behalf, had given lawful consent.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered provider had not done all that was reasonably practicable to assess and mitigate the risks to people living in the home.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The registered provider had not ensured the systems in place were effective to make sure people were always protected from improper treatment and that staff always worked within

	the requirements of the Mental Capacity Act 2005 and deprivation of liberty safeguards.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 15 HSCA RA Regulations 2014 Premises and equipment the registered provider had not ensured that the environment facilitated the prevention and control of infections in line with current legislation and guidance. It was also because maintenance was not being planned and faults dealt with in a timely manner to keep the environment safe.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The monitoring systems being practiced were not being consistent in identifying where improvements were needed in the quality of the service and to be able to mitigate risks.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The registered provider had not made sure that all staff had received the training relevant to their roles and that they were competent to carry out the practical aspects of their roles.