West Heanton Limited

West Heanton - Residential Home

Inspection report

Buckland Filleigh
Beaworthy
Devon
EX21 5PJ
Tel: 01409 281754
Website: www.westheanton.co.uk

Date of inspection visit: 3 and 30 December 2014
Date of publication: 16/02/2015

Ratings

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

Overall summary

These inspections visits took place on 3 and 30 December 2014 and were unannounced.

West Heaton Residential Home is a rurally located care home which provides care and support for older people who may be living with dementia. The home can accommodate up to a maximum of 23 people. West Heanton Limited is a family based business. The home does not provide nursing care. People's healthcare needs are met through the local community services, such as the district nurses and GPs. There were 23 people residing in the care home at the time of our inspection.

The service has a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like

Summary of findings

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

At the last inspection, on 2 May 2014, we asked the provider to take action because the standard of record keeping did not ensure people were protected from the risks of unsafe or inappropriate care. We found during this inspection that record keeping continued to put people at risk of unsafe or inappropriate care because the home did not have an effective system for records management.

People's need's were monitored but this did not always lead to a timely response to concerns, such as weight loss. The home relied on community services to act once problems had developed. Systems, such as risk assessment tools, were not used so the home could identify where risk was increased, and take steps to prevent problems from occurring.

The service had inadequate systems to ensure health and safety were promoted at all times. However, there were arrangements for listening to people's views and there were reviews of how the home was run which had led to changes, such as the staff training arrangements.

Staff did not adequately understand the Mental Capacity Act (2005) (MCA) and Deprivation of Liberty Safeguards (DoLS) and how they applied this in practice. They understood the importance of providing people with choices and listening and responding to their preferences, where expressed. They were clear they would not act against people's wishes. No person was being deprived of their liberty and decisions were made in their best interest.

People felt safe but arrangements relating to reporting abuse were not robust, although they were under review.

People's needs were generally met by sufficient numbers of staff who considered their training to be effective and who were encouraged to take qualifications in care. Staff received supervision and support for their work and felt able to take any concern or enquiry to the registered manager. The arrangements for recruitment of staff protected people from staff who might be unsuitable to care for them.

Medicines management protected people using the service. It was well organised and ensured people received the medicines they required at the time they required them. People had a nutritious diet available to them although some requested more variety and people did not have the choice of whether they received sugar supplements or not.

People felt valued and were cared for. Time was set aside for additional one to one time with staff, called "TLC". There was a variety of activities and engagement with the local community, where people had friends and neighbours.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Changes in care needs were not responded to in a timely manner to promote people's health and welfare. The home lacked systems to ensure risk was reduced and managed.

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

Requires Improvement

The service was not always safe.

Systems to protect people from abuse were not robust although they were under review.

Fire alarms were not regular checked and recorded. Maintenance and servicing of equipment were up to date and the premises was well maintained.

People's needs were generally met by sufficient numbers of staff.

Accidents within the home were monitored on an individual basis and actions were taken to reduce any identified risks.

The arrangements for recruitment of staff and medicines management protected people using the service.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff did not fully understand the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) and how they applied this in practice. They understood the importance of providing people with choices and listening and responding to their preferences. People felt safe and were not deprived of their liberty. Decisions were made in their best interest.

People received sufficient to eat and drink and a nutritious diet was available but people told us they wanted additional choice of menu.

Staff training was considered to be improved and was under review. Staff received supervision and support in the roles.

Is the service caring?

Good

The service was caring.

All people associated with the home said how caring the registered manager and staff were and this was evident from observing people receiving care and support.

End of life care was considered by health care professionals to be of a high standard and ensuring dignity and respect.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans were not used to inform and direct staff about people's health and social care needs and changes in people's health did not always lead to a timely response.

Summary of findings

People felt listened to and their views were sought.

People had a wide range of activities available to them which promoted their well-being.

Is the service well-led?

The service was not always well-led.

An excellent ethos of support by the management and a caring attitude, had not led to adequate systems of working which protected people from identifiable risks. Quality assurance, risk assessments and care plan review systems did not drive improvements, or raise standards of care consistently.

Requires Improvement

West Heanton - Residential Home

Detailed findings

Background to this inspection

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

The inspection visits took place on 3 and 30 December 2014 and the visits were unannounced. The inspection team consisted of one inspector for both visits.

Not everyone was able to verbally share with us their experiences of life at the home. This was because of their dementia/complex needs. We therefore used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. Before our inspection, we reviewed the information in the PIR along with information we held about the home, which included incident notifications they had sent us. A notification is information about important events which the service is required to tell us about by law. We contacted a care manager and district nurse to obtain their views about the care provided in the home.

During our visit we spoke to six people living at the home, 10 staff and the registered manager. We looked at records which related to five people's individual care, three staff files and policies which related to complaints, dignity, care of the dying and accidents and emergencies. We looked at records of equipment servicing, staff training/deployment, recruitment and some quality monitoring audits.

Requires Improvement

Is the service safe?

Our findings

People could not be assured that the home environment was safe. The home appeared well maintained and records of servicing and maintenance showed these were carried out regularly. For example, we saw the safety checks for the tail lift on the home's minibus and that an external fire safety company had visited and serviced equipment. However, weekly fire safety checks had not been recorded since April 2014. The registered manager said he toured the home daily and was fully aware of any issue regarding fire safety. He had also ensured a very detailed fire safety plan for the home.

People were not fully safeguarded from abuse. The PIR stated that less than half of the staff had received training in safeguarding in the last 24 months. However, staff were able to describe types of abuse and said abuse would not be tolerated at the home. All said they would report any concerns to the registered manager but they were unsure about reporting concerns to agencies external to the home that hold the responsibility for protecting adults from abuse. The home's policy on safeguarding adults was available to staff but was being reviewed at the time of the inspection.

Staff and the registered and deputy managers were unaware that, where a person using the service had been aggressive to another, this must be reported to the local authority. However, staff had acted to ensure people were safe where two people had found each other's company difficult. In addition, following our first visit the registered manager made a safeguarding alert relating to an incident of aggression between two people at the home and so had reported the incident appropriately for those people's protection.

People told us they felt safe at West Heanton. Their comments included, "Very much", "Yes" and "(The registered manager) is a very nice man. He makes me feel comfortable." People appeared confident and happy when interacting with staff.

There were arrangements in place should there be other emergencies. For example, the home had a backup generator and contact details for emergency services were displayed on a staff notice board.

People's care needs were being met by a sufficient number of skilled and knowledgeable staff. The registered manager told us how additional staff could be called upon in an emergency or if people's needs increased. One care worker felt staffing in the morning was sometimes an issue as several people wanted to get up at a set time but no person using the service mentioned this as a concern. Another care worker, asked if there were enough staff to meet people's needs said, "Sometimes yes and sometimes no" referring to staff who phoned in sick at short notice.

Staff told us there were nine people needing two staff to provide their care, five people needed assistance with eating and three people would become anxious or wander without purpose requiring staff support. The staffing rota showed there were three care staff on duty in the mornings, three in the afternoons and two during the night. In addition were the registered manager, deputy managers, administrative, activity, maintenance, catering and domestic staff. There was laundry and cleaning cover at the home seven days a week. This meant care workers were able to concentrate on delivering care and not domestic tasks. People were also frequently occupied by activities staff.

Accidents within the home were monitored on an individual basis and actions were taken to reduce any identified risks. Examples included providing antibiotic therapy and re-organising furniture to stop a person sliding onto the floor. A folder called 'Incidents or Changes' was used to record any identified incidents and actions taken to prevent re-occurrence. This included records of a mistake made by the pharmacy identified at the home and promptly dealt with. The registered manager said the use of this folder system was in its early days but staff were being encouraged to use it more.

Staff records showed recruitment was well organised. Two care workers said they had not started working at the home before recruitment checks were completed. Staff files included completed application forms. Pre-employment checks were done, which included references from previous employers, health screening and Disclosure and Barring Service (DBS) checks completed. These checks identified if prospective staff had a criminal record or were barred from working with people at risk.

Medicine management was well organised and handled in a safe way. Medicines were ordered and delivered from two small surgeries in the area. We were told a pharmacist had recently visited so they could understand the way the home operated and improve their assistance. The deputy

Is the service safe?

manager said the home was very happy with the arrangements and the rapport with the pharmacies. Medicines were scanned into the home using a bar coding system which, it was felt, made the arrangement safer..

Medicines were safely stored in locked cupboards in the 'treatment' room. Each person had a designated box with a photograph and relevant details in which the medicines were stored. Each person had a care plan describing their medicines, what they were for, their medicines routine, preferred method for taking the medicines and other important information. For example, "Will often chew her tablets before swallowing them."

One person was able to administer their own medicines as this was their choice and they were able to do so safely. We saw how the deputy manager administered medicines to other individuals when they got up for breakfast. We were told staff did not administer medicines until they were felt to be competent. This was generally after "Three lots of training and if they feel confident" but all staff received some medicine training even if they did not carry out medicine administration.

Medicine records were clear and complete and included why any medicine had not been given. It was clear what maximum dose could be given in a 24 hour period where the medicine was available "as required". For example, medicines for one person was prescribed for times when they were "agitated" and it was clear when the medicines could be administered. The medicines policy provided a wide range of details for staff relating to people's choice and consent to receiving medicines and a section on 'What could go wrong'. For example, one person was refusing their prescribed medicines, which had been managed well. There was clear information for staff about how to proceed with this concern and how the person's GP was involved for advice.

Requires Improvement

Is the service effective?

Our findings

People enjoyed living at West Heanton. However, improvements were needed in relation to acting in people's best interests, reducing risks relating to the development of pressure damage, the variety of food available and the way that information between staff was communicated.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. DoLS provide legal protection for those vulnerable people who are, or may become, deprived of their liberty. The registered manager had some knowledge of a Supreme Court judgement on 19 March 2014 which had widened and clarified the definition of deprivation of liberty. He had yet to make necessary applications where restrictions might fall under the widened definition however.

Staff did not fully understand the MCA and Deprivation of Liberty Safeguards (DoLS) and how they applied this in practice. They had not received training in MCA and DoLS. However, they understood the importance of providing people with choices and listening and responding to their preferences, where expressed and they did not act contrary to people's consent.

The MCA provides the legal framework to assess people's capacity to make certain decisions, at a certain time. There was only one record of such an assessment having been done which indicated the home needed to extend the breadth of those capacity assessments. Where staff believed people did not have the capacity to make a decision, a best interest decision was made involving people who know the person well and other professionals, where relevant. An example was the use of pressure mats to monitor people's movements. Those people told us they did not know why the mats were being used but other information indicated they might not have the capacity to make such decisions and so their family had been asked on their behalf. A care worker told us "You never go against people's will" and this was what we observed.

There was not always methods for reducing risks to health. For example, staff reported to community nurses when they saw a person was becoming "sore". However, this indicated that skin damage had started. There was no tool in use for assessing the risks of a person's susceptibility to pressure damage and therefore appropriate action for the prevention of skin pressure damage was not always taken.

Staff were able to describe people as individuals, with preferences and idiosyncrasies. There was a strong emphasis on different staff roles and levels of responsibility, with care workers referring to senior care workers and/or different managers. The way that information was communicated to staff was not always adequate. Staff felt they did not always receive a timely hand over of information when they started a shift, adding, "You don't know if x, y or z is happening that day." One said they did not know a person had a skin injury until they went in to wash them.

A physiotherapist and trainer were employed to visit twice weekly to provide physical activity and mobility advice and support. This reduced the risk of falls as people maintained their abilities for longer. People were supported to make hospital visits and receive routine health checks. For example, an optician was visiting during our inspection.

People received sufficient amounts to eat and drink and a nutritious diet was available. However, they did not speak positively about the food provided. One person told us the food was "alright" and another person said it was "average." The menu did not offer much variety. There was a four week menu plan. 23 of the 28 days the lunch time meal was meat and vegetables with potatoes cooked in different ways. Once there was an option of rice. Five of the 28 days there was fish and potatoes. There was a wide variety of attractive desserts available. The tea time meal did offered some non-meat choices and more variety, such as soup, mushrooms on toast, kippers and scrambled egg. An activities worker organised a coffee morning and they told us it included fresh fruit. One person said the food was "well cooked and nutritious" and in plentiful supply. Asked about the choice they said they would like pasta and spicy foods but they did not get these at the home. The registered manager said people's preferences were taken into account. Information in the PIR said the main areas of feedback from people had been about meals and food and that different menu options were tried.

A cook was available each day between 7am and 8pm. They said there was no choice of the main meal of the day but, if there was something a person did not like another meal would be made available. Information in the PIR

Requires Improvement

Is the service effective?

stated the home provided freshly cooked food using local food providers and residents were assessed on their eating to ensure they have an appropriate diet - cut up or soft when needed. The cook told us “We do a lot of mushy meals” meaning soft diets were available for people where required. They said two people required a diabetic diet and gave the example of stewed apple with sweetener and custard, adding “and the rest of them have it as well.” Therefore people who were not diabetic were only offered the diabetic option without them knowing.

Training, supervision and support were in place for staff. Staff told us that they were encouraged to undertake qualifications in care. One said, “Training is good. I am doing my National Vocational Qualifications (NVQ).” Information in the PIR included that 29 out of 44 staff had achieved qualifications in health and social care.

Staff listed some of the training they had received, such as distance learning in first aid, dementia care and medication. We were told, “There have been more courses recently.” Training records were not up to date and there was not an accurate record of staff training but the PIR included that 11 staff had trained in dementia care, 26 in moving and handling, 20 in positive behaviour support and eight in pressure care.

Staff received an induction when new to the home. This meant that staff had started the process of understanding the necessary skills to perform their role appropriately and to meet the needs of the people living in the home. A staff member described it as, “A book to go through and they showed you around the home. The induction was OK.” A deputy manager was changing their role to training manager and was actively updating the home’s training arrangements.

The PIR included that 43 of the 44 staff had a named person that provided them with regular supervision (one to one sessions between staff and management). Supervision was arranged for every couple of months and every staff had received an annual appraisal of their work. There were also staff meetings, the last held October 2014. This included discussion about training and staff practices.

There were links with Devon Care Home Owners and the Federation of Small Businesses for specific guidance and information in best practice.

Good

Is the service caring?

Our findings

We saw and people told us that the service was caring. One person told us they were very happy at the home and the staff were "absolutely super." Thank you cards dated 2014 showed people's families were pleased with the service. Examples included "(Thank you for the) enormous patience and friendliness. I couldn't be more grateful" and "Thank you for your continued kindness." There were no negative comments from people about the attitude of staff at West Heanton.

We saw staff helping people throughout our two visits. For example, one person was being directed to their room and the staff member said, "This is your room" in a kind and friendly manner. Our observation over the lunch time period showed people being assisted in a relaxed and unhurried manner. One staff member asked "All finished. Is it nice?" Another offered assistance and sat helping a person struggling to eat. That staff member spoke gently, politely and with respect. People were asked, "Who would like a sherry or grapefruit" and their dessert preference. There was some banter and fun between one staff member and people in the dining room. Staff treated people with patience, respect and dignity. For example, care was delivered in private and staff knocked before entering people's rooms. One person was discreetly supported to change their clothing when they were not dressed in a "dignified manner."

The registered provider told us staff worked regular shifts as this allowed them to get to know people using the service "on a really good basis" such as family visitors and any preferred television programmes. The PIR stated there was a project to record people's backgrounds and life history to help staff understand people better. We saw some examples.

Family and friends were encouraged to visit and could help themselves to drinks from a kitchenette. Family members would speak to the "management" about their relatives with suggestions and this provided helpful advice.

The home had sent 'Your Views Count' questionnaires to people; we saw some dated August and October 2014. The registered manager said this was a "work in progress". He said residents' meetings had not worked and he was trying to find the best ways for people to give their views. Different methods were being tried. For example, in June 2014 each person was asked: Are you happy with the home; the food; the staff? The replies had been positive.

West Heanton provides end of life care. 'My last wishes' forms had recently been sent to people's families and the provider stated in the PIR that staff had been allocated time to spend on a 'one to one' with residents to help support them. A district nurse spoke highly of the end of life care provided and how well staff followed advice and ensured people received "very good outcomes."

Requires Improvement

Is the service responsive?

Our findings

Each person had a computerised care plan. Care plans are a tool which should inform and direct staff about people's health and social care needs so that care is provided in a timely and consistent manner in line with people's preferences and needs. Some of the plans contained good detail about people's preferences, such as preferred type of bread, breakfast choices and newspaper. Some were repetitious and did not provide constructive information about the person's needs or how staff were to respond to those needs. For example, for one person the section called 'general overview' of their behaviour had identical information as the section called 'problem'. The goal was to enable the person to have less outburst of anger. The registered manager was able to describe the triggers to the person's behaviour but these were not recorded to inform staff practice. That person had lost a significant amount of weight since admission in August 2014. Their care plan goal was to encourage them to eat a "good diet and well presented". Their GP must have been informed about the weight loss because the person had been prescribed supplements to boost their weight but the registered manager could not find records of GP involvement. The person's records stated they did not like the supplements and often refused them but this had not led to a change in care plan. During our second visit we found there had been no further weight checks and so it was not known if they had lost more weight. A community nurse said they had no particular concerns about the care provided at West Heanton, and staff were good at following advice, but they were not always informed of concerns quickly enough and things could potentially "get missed".

There were many examples of records with no date or signature, which made understanding their relevance at the time difficult. It was clear care plans were not used as tools for planning people's care or informing staff of how to deliver the care. This could lead to people's needs not being met. We saw two excellent examples of such information pinned up in the staff office but not included in the 'care plan'. The registered manager told us they recognised their system needed to be reviewed.

Confidentiality of information was maintained. The registered manager had access to all data which related to the running of the service and each member of staff had a different level of access, there being five in total. This promoted confidentiality of information. There was a previous breach of record keeping, and a action plan was supplied to show how the home intended to improve. However, for a second inspection it was found the records did not protect people from unsafe or inappropriate care.

The home's policy on dignity stated, "We do not tolerate any practices which may impair a person's dignity". However, one staff member in the dining room said to another, "There's pudding there for the feeders". This term does not afford those people needing assistance dignity and respect but it was not challenged in response by the second staff member at the time. The registered manager told us this would be addressed.

People had their needs and requests responded to, telling us, "Happy, friendly. Nothing is too much trouble", "Very happy here" and "There is enough variety". Staff were generally able to describe people's individual needs and responded to them. People were offered information when care was provided and encouraged to make daily choices, such as what to wear, do and eat. For example, one person liked whisky in their porridge and so whisky had been bought for a Christmas present.

An activities coordinator was employed four days a week. They began those days in a care role in what they described as their "TLC" time, which meant they dedicated additional time to an individual person who might otherwise become isolated. For example, to have a pamper bath and "make them feel special". A personal trainer also visited twice a week to spend time with people. For example, one person would be assisted to go for a walk and another would have an arthritic hand massaged. There were many examples of activities at the home. These included a reminiscence tree, discussions about topical events, arts and crafts and arm chair games and quizzes. Coffee mornings made for a social event which the activities coordinator facilitated and were also used to gain people's views about the service and what they wanted at the home.

People were supported to maintain connections with people they knew. There was a day care arrangement in place and a church service each month when the local community was invited in. This helped maintain friendships and neighbourhood links. On occasions a care worker was rostered to provide individual care, such as nail care and a hairdresser came in twice a week. We were told whilst people had their hair done, "they have time for a chat".

Requires Improvement

Is the service responsive?

A complaints procedure was in view by the home's entrance. It stated the home welcomed complaints and included timescales for action, meetings with the complainant and follow up actions. One person said if they had any complaints they would complain to the (registered manager) adding, "We are good mates." A second person said they would have no concerns about making their opinion known. The registered manager informed us there had been two complaints made in the last 12 months using the formal complaints procedure and that both were resolved. They said the main areas of feedback had been around food and following this the meat supplier was changed and likes and dislikes were recorded in a different way.

Requires Improvement

Is the service well-led?

Our findings

Systems of working, which would make the service safer and more effective, were not always completed or embedded.

A computerised calendar system was in place to indicate when, for example, servicing of equipment was due but fire alarm checks were not included and so the system had not prompted that these needed to be done and there was no record of their completion for many months.

Training records were not completed and did not describe the training staff had received, or when training needed to be reviewed. However, a training manager post was due to start in January 2015 and that training manager told us, "The training matrix is getting going again." They were already making arrangements to meet staff's training needs.

Records could not be guaranteed to provide up to date information based on people's preferences or needs and staff did not use care plans for information. Records were not always readily available so the care provision could be joined up. Some monitoring records were in a drawer whilst others were on the computerised system. However, the care required for two people was displayed on a cupboard and contained good detail for staff on how to meet the individual needs being addressed.

The home's computerised system highlighted areas which required more immediate attention but a concern about a person's weight had not led to timely action being taken. Arrangements for communicating information were not robust. For example, community nurses expressed frustration at not always knowing who the staff were or their role, finding the person they were visiting, getting information and being able to feed back information to a staff member.

There was a clear intension that people using the service should live with dignity, respect and in the knowledge they mattered. For example, the home's policies made clear the ethos of the service was one of respect for people's choice and staff time was provided to make people feel cared for and special. Staff meetings made clear what was and what was not acceptable practice, changes being made and that staff were valued and their efforts appreciated. People using the service knew the registered manager well and greeted him with a smile. He was active at the home on a day to day basis and treated people as friends.

Staff could take any concern or ask any question of the registered manager or senior staff. One staff member, asked if the home was well-led said, "Oh my gosh, yes." Four care workers said there were more managers and senior care workers now on each shift and 'well-led' depended on which staff were on, how the team worked and how people using the service were that particular day. Staff demonstrated they understood the principles of personalised care through talking to us about how they met people's care needs.

There were arrangements in place to seek feedback from people who used the service and staff. This involved questionnaires, resident coffee mornings, staff meetings and supervision, managing complaints and chatting with people and their families. For example, staff had requested that management work at weekends as they had done previously, and so this had been arranged.

Regular audits were undertaken at the home. For example, medicines management, complaints and individual accidents. There were no care plan audits. The registered manager said it was "early days" with regard to a new incident reporting method intended to encourage staff to recognise and report concerns without fear. Incidents were being reported and acted upon, such as medicine errors. Staffing was under regular review and a bonus scheme had been introduced which awarded staff for training, attendance and reliability. Staff were encouraged to progress in their career and take a pride in the work they did and those we met demonstrated a professional and well thought through approach to their work.

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 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 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services **Proper steps were not always taken in a timely manner in response to a change in people's health care needs.** Regulation 9 (1) (b) (ii)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers **The provider had not sufficiently effective systems in place to identify, assess and manage risk.** Regulation 10 (1) (b)