Primary Medical Solution Limited

Heathside House

Inspection report

Heathside Lane
Goldenhill
Stoke-on-Trent
ST6 5QS
Tel: 01782 771911
Website:

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Ratings

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

Overall summary

We inspected Heathside House on 2 and 3 December 2014 which was unannounced. At the inspection on 29 May 2014, we asked the provider to take action to make improvements to the way they supported people, staffing levels and the management of the service. We found that these actions had not been completed and found further areas of concern.

Heathside House is registered to provide accommodation and personal care for up to 44 people. People who lived at the home had nursing and residential care needs and some were living with dementia. At the time of our inspection there were 29 people who used the service.

The service did not have a registered manager in post. 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 2008 and associated Regulations about how the service is run.

Staff knew how to recognise and report suspected abuse and the provider had acted appropriately where they were concerned about possible harm to others or abuse. Staff knew about whistleblowing and who they should report concerns about care to.

Staff said they had received essential training to meet the needs of people who used the service.

We found that there were insufficient suitably experienced nursing staff available to meet people's assessed needs. The provider did not have an effective system in place in relation to the provision and retention of nursing staff.

There were continued concerns about the accuracy of information available. This was because some care plans had not been reviewed regularly and there was a lack of evidence of people's involvement in planning their care.

Medicines were managed appropriately.

People told us the care staff were kind and caring and they felt safe living at Heathside House. Relatives we spoke with confirmed they were free to visit at any time.

We found there was a lack of support for the clinical supervision and professional development of staff.

People made positive comments about the food they were served, but would benefit from improved food choices.

Complaints were investigated and recorded but information on how to make a complaint was not visible in the home.

The provider had not had a registered manager in place since May 2014, meaning there was a lack of management leadership and oversight.

Systems were not in place to monitor the quality of the service provided; improvements were needed to ensure that actions were in place where concerns had been identified. This was a continuing breach.

We found a number of breaches at this inspection you can see what action we told the provider to take at the back of the full version of the report.'

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not consistently effective.

Care staff knew how to recognise and report suspected abuse.

There were insufficient numbers of qualified and skilled staff available to provide the support people needed to keep them safe.

Risk assessment and care planning was not always up to date.

Requires Improvement

Is the service effective?
The service was not consistently effective.

Mental capacity assessments had been completed, but evidence of people's consent to treatment or care was not always evident.

Care and nursing staff did not always have access to appropriate access to supervision or clinical leadership.

Health care needs were recorded and advice from health professionals sought to ensure the need was met.

Requires Improvement

Is the service caring?
The service was not consistently caring.

People were treated with kindness and were positive about the support they received.

Staff demonstrated how they respected people's privacy and dignity.

People and their relatives were not always included in decisions about people's care.

Requires Improvement

Is the service responsive?
The service is not consistently responsive.

People's care plans were not always personalised to the individual for whom they were written, and people were not always involved in their review.

Some people's care had not been reviewed which put them at risk of inconsistent care and of not receiving the support they may need.

People said they felt able to raise concerns, but improvements to people's access to the complaints procedure was needed.

Requires Improvement

Is the service well-led?
The service is not well-led.

A lack of consistent manager meant there was a lack of leadership in the home.

Inadequate

Summary of findings

A failure to analyse and assess risks for people meant they were not protected from harm.

There was a lack of clear understanding of quality assurance and the need for continuous development of the service.

Heathside House

Detailed findings

Background to this inspection

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

This inspection took place on 2 and 3 December 2014 and was unannounced. The inspection team consisted of two inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. Our expert had personal experience of caring for supporting older people.

Before the inspection the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the information included in the PIR along with information we held about the home such as feedback from commissioners and notifications of incidents/safeguarding concerns that had occurred at the service.

During the inspection we spoke with twelve service users, eight staff and three visitors.

We viewed six records about people's care and records that showed how the home was managed. These included staff training and records for staff employed at the home, care records and records relating to the medicines management, and staff rosters. Prior to and following the inspection we spoke with the commissioners of the local authority and other professionals who had an interest in the service to gain their views.

Requires Improvement

Is the service safe?

Our findings

At previous inspections we had reported on poor staffing levels and the provider's failure to recruit suitable experienced staff. This was a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Prior to this inspection we had received a number of concerns about staffing levels, the high turnover of staff and the use of agency staff. It was alleged that this meant people who used the service did not receive consistent care and support from staff who knew them well. At this inspection we found there had been deterioration in the staffing arrangements and there were insufficient nursing staff to meet people's needs.

People we spoke with made comments including, "There's a lack of carers and a lot of strangers coming in to help and we sometimes have to wait quite a while for things" and, "There is not always enough staff and sometimes you have to wait a long time when you buzz. It can be up to half an hour in the mornings if I want to get up". A third person said, "Agency staff often don't know much about you and they have to ask you what to do when they come in." We were also told by a staff member that, "We need more regular staff that have insight into caring and a good manager to sort things out now".

We observed the lunch time experience. Staff told us lunch was served at around 12.30pm. Staff started to bring people to the tables at about 12.15pm. Most people needed to the assistance of a hoist to move and were transferred from their chairs into wheelchairs and taken to the table. It was after 12.45pm before the first meals were served due to the time taken to support people. We observed people who fell asleep at the table whilst they were waiting and one person told us, "We are always waiting for something".

We were told by the staff and we saw on the rota that there were high nursing staff vacancies. There was only one nurse employed by the provider. The remaining nursing provision was supplied by agency or bank staff. The staff we spoke with said the high use of agency nurses together with the vacancies for care staff and management, made the consistent provision of high quality support to the people on every shift difficult to achieve. The provider told us they had not been able to recruit permanent nursing staff to the vacant positions. We noted from the staff rosters that staffing numbers and care staff experience varied and staff numbers were not maintained on all shifts.

We observed and spoke with staff about those people who needed to be repositioned to ensure they were not at risk of harm. A care staff told us, "Sometimes there are not enough staff to ensure they are turned when they should be". During our observations people were not engaged in activities or hobbies and interests for long periods of time. A care staff told us, "If we had more regular staff we could do more things with everyone, but we can't." Another staff said, "The high use of agency has an impact on how much we can do, we have to induct them and guide them. Which means we don't have as much time to be with people".

These issues were repeated breaches of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

At the last inspection in May 2014 we found the provider did not have effective systems in place to assess and monitor the quality of care. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Four of the six care plans we looked at had been reformatted and held well documented and up to date risk assessments. The risk assessments gave staff clear information on how to mitigate the identified risks. The two other care plans held fully documented risk assessments which were in the provider's original format. The care plans and risk assessments had not been updated since July and August 2014. There was no evidence that these care plans had been audited or monitored which meant that people may be at risk of inadequate or inappropriate care and staff did not have access to current information or support guidelines to enable them to deliver up to date and appropriate care

Many of the people who used the service required wheelchairs to mobilise and it was noted that not all the chairs in use had foot rests fitted. We saw when footrests were fitted staff did not always make sure people's feet were properly positioned. Foot rest on wheelchairs must be used to ensure the risk of entrapment and injury is reduced. A staff member told us, "It's a real problem I check them every week and re fit the foot plates, but each week I

Requires Improvement

Is the service safe?

have to replace them again". This meant that these people were not always supported to remain safe from the risk of injury and harm because there was a lack of effective management of the risk.

The provider did not have systems in place to analyse and to manage incidents or accidents effectively. There was evidence that accidents and incidents were recorded but no evidence that the provider had checked for trends and patterns or that any actions were taken to lower the risk of further incidents occurring

These issues are continued breaches of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activity) 2010.

One person we spoke with told us, "I do feel safe here. I don't like TV so I choose to sit in the little sitting room (Conservatory) with another lady. Staff come to check I am ok". Another said, "I feel safe". The staff we spoke with told us they regularly received safeguarding training. They understood the concept of keeping people safe and were aware of what actions to take should the situation arise. They said they would not hesitate to take action if they felt a service user was suffering any form of abuse.

Staff were aware of the need to 'whistle blow' on poor practice and felt confident to do so. One staff member told us, "I know what whistle blowing is and I would act straight away if I saw something that was not right or unsafe. If it meant immediate risk I would tell the person themselves and get them to stop. Otherwise I would go to managers, directors and if necessary social services or CQC".

We observed how medicines were administered. We saw nursing staff speak with people who were prescribed medicines and stay with them until the medicine was taken. The nursing and senior care workers we spoke with had received training in medicine administration. Permanent staff at the home who were responsible for medication administration had also undertaken competency checks.

We saw the record keeping on the medication administration records (MARs) and controlled drugs was accurate. The medicine trolley was well organised and all the medicines were in date. A staff member told us how they managed the ordering and supply of the medicines people required.

We saw that all medicines were stored securely and were not accessible by anyone not authorised to handle medicines. Medicines which required cool storage were kept in a drug fridge and temperatures were monitored to ensure they were within the recommended range.

Requires Improvement

Is the service effective?

Our findings

None of the people we spoke with raised concerns about the availability of food or drinks. However not everyone was able to tell us if they had sufficient to keep them well. We identified people who were at risk of dehydration or malnutrition.

The records we looked at did not demonstrate they were receiving sufficient drinks over a 24 hour period to keep them healthy and to meet relevant guidance. We found examples where four people had not received the recommended minimum fluid intake and other examples where people had not received anything to drink from 5pm to 8am.

Each daily fluid monitoring chart we saw contained an up to date indication of the amount of fluid people had taken, where this needed to be monitored. But there were no total amounts completed at the end of the day. There were no target amounts on the sheets which would act as a guide to the staff. There was no evidence of regular assessment or monitoring of people's fluid intake or management of the risks relating to the health and welfare if they did not consume sufficient food or drink.

These issues were a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

One person we met had diabetes. We saw they had care plans in place for the management of their diabetes and for blood sugar level monitoring. It was not evident from the information in the care plan what the normal blood sugar level for the person was, or when the staff should contact health professionals for advice. We noted a wide variance in the blood sugar levels recorded and spoke to one staff member who said, "If the levels are high I usually check it again a little later". The staff we spoke with was unable to identify what constituted high blood sugar levels for that person or provide any evidence in the records that this had happened. This meant there was a lack of planning and delivery of care to meet the person's individual needs and ensure their welfare.

These issues are a breach of Regulation 9, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

One person we spoke with told us, "I think the staff know what they are doing most of the time". A relative said, "I worry about the knowledge of the staff who don't work here regularly". Staff we spoke with told us they had received essential training to ensure they could meet people's needs safely. This included, manual handling, infection control and health and safety. Two of the staff we spoke with said that a new business manager had recently started work at the home. They said they were arranging one to one meetings with all the staff and they looked forward to this. They told us these meetings would help them to identify any training needs they may have.

CQC is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) and to report on what we find. The MCA sets out the requirements that ensure decisions are made in people's best interest when they are unable to do this for themselves. DoLS are part of the Act. They aim to make sure that people in care homes are looked after in a way that does not inappropriately restrict or deprive them of their freedom. None of the people who used the service were subject to DoLS authorisations; we did not see any evidence of unlawful restrictions during our observations.

People we spoke with told us they were asked how they wanted their care to be provided. We saw that three of the care plans we looked at held documentation which people had signed on their admission to the home to give consent to their care. The care plans we reviewed held documentation to confirm each person's MCA assessment had been undertaken and recorded in the past three months. This meant their capacity to consent to care and treatment had been assessed. People who have capacity to make the decision can decide not to be resuscitated in the event of a cardiac arrest. People who don't have capacity can have decisions in their best interests. Two of the care plans we looked at held up to date documentation of the person's do not attempt resuscitation (DNARCPR) status. The documents were signed and dated by the person's GP or consultant, with no evidence of the person's involvement or that of their supporters or family. One of the documents showed that discussions had taken place with family members.

People we spoke with gave us mixed views about the food they were offered, received and their food choices. Comments included, "The food is good on the whole" and, "No choice of main course, they don't offer anything else if

Requires Improvement

Is the service effective?

you don't like it but you can have sandwich. I am pretty satisfied with the food". "Food is wonderful" and, "I've only got to ask for a drink and it is there for you" and, "Some days the food is very good and some days not so good". We observed how the main meal of the day was served and we noted that people weren't offered a choice of meal and all the meals were served with gravy; no one was asked if they wanted it.

Where people needed to have support to eat their meals we observed the staff gave their full attention to the individual, positioned themselves appropriately, explained what they were doing and offered encouragement. We heard one staff encouraging, "Are you going to have some more dinner for me"? "Yes okay, are you ready"? "Well done and would you like some more, or are you ready for a drink"?

We saw people could access care from other services such as from the GP. Other clinicians and district nurses visited regularly. We saw in people's care plans that people had regular support from chiropody, opticians and specialist nurses. We saw that where people had pressure ulcers, advice on their management had been obtained from the district nurse and a risk assessment had been updated.

Requires Improvement

Is the service caring?

Our findings

People we spoke with gave positive accounts of their care and treatment by staff. Comments included, “Lovely, staff are as good as gold” and, “Most of the carers are helpful and friendly and a couple of the agency staff are quite good. They are caring and mostly polite and you can have a joke with one or two of them”.

From our observations all the staff were seen to be very caring and respectful of the people at Heathside House. The care staff we spoke with knew the people well and had learned what they liked and did not like. They knew what was important in the lives of the individuals. One staff member said, “It is important to me to think that I am giving the best care I can, as if it was to my gran”.

One person we spoke with and their relative confirmed they were supported to receive the spiritual support they liked. A staff member told us they felt it was important to treat people as individuals and try to meet their needs. All of the care plans we reviewed held information about people’s religious beliefs and one person retained links with a church group they had been member of before their admission to the home.

People and their relatives provided mixed accounts of their involvement in decision making. One person said, “They gave me an agency worker as key worker which is not so good”. A relative told us, “They are quite good at letting you know if things happen or if not well. Carers also talk to you about things and take real interest in families and in learning about people and their care”. Staff told us people and/or their relatives were not always included in the review of care plans or their revision. We were told that they were not as a matter of course informed or invited but they had been included when initially planning each person’s care following admission. One person told us, “I was spoken with initially but not at all since”.

We observed the staff ensured each person was supported to maintain their dignity. During meals, the staff ensured the people were keeping themselves as clean as possible. The staff we saw supporting people in their rooms to take drinks, carefully helped people to reposition before they gave them their refreshments. We saw staff knock on doors and ask to enter the room before doing so. One person told us, “They always knock before coming into your room and explain what they are going to do”. When people were using a hoist, staff spoke encouragingly to people, explained what they were doing and ensured the person was covered to ensure that people’s dignity was not compromised.

Relatives confirmed they could visit the home at any time. A visitor told us, “My friend and I can come in when we like to see [person using the service]”.

Requires Improvement

Is the service responsive?

Our findings

At the last inspection of May 2014 we found the provider had not been able to demonstrate that people's social and occupational needs could be met. There was a lack of stimulation and activity. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We asked people who used the service, staff and visitors about activities in the home and whether individuals were encouraged to maintain hobbies or try new interests. We received mixed views and were told, "The TV is on most of the time but I don't watch it, I do a lot of puzzles and word searches. Or things like this word game. We do Bingo as well and play cards." Another person said, "[Person who used the service] chooses the channel, no-one else seems bothered". A third person commented, "There is always something going on I watch TV and read. We have quizzes. Have our hair and nails done –all sorts. Can't think at the moment of what we have done recently".

We did not observe any of the people sitting in the lounge or who stayed in their bedrooms undertaking any meaningful activities apart from watching the TV. We asked the activities organiser what was available for people who remained in their bedroom. They told us that when they were able they popped in for a chat.

A visitor told us, "They arrange trips but [person who used the service] doesn't go. They like to watch TV mostly and sit in this lounge as they like to see what goes on. They played Bingo yesterday. They have a new entertainments person started –for a few weeks nothing has been happening but now it's kicking in again." A staff member told us, "There is not enough stimulation in my view and we have no time to sit down and interact with residents although we try to as and when, but would love to do more. I love to have a laugh and joke with people and sing along with them."

We did not see any evidence of the needs of people living with dementia being addressed. The corridors, doors, walls and living areas had no visual stimulus displayed. To aid people living with dementia to move around the home and to orientate themselves to time and space There were no reminiscence items or pictures which may help people to remember the past. There was no use of colour schemes or signage which may help people get around or know what day it was. We asked the activities organiser if they had received any specialist training to meet the needs of the people living with dementia. They said they had not had any specialist training only 'learning by experience'.

These issues are continued breaches of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

None of the people we spoke with were able to recall being involved with the planning and review of their care but were happy with their care they received. A visitor told me, "I was involved in their care plan when they were admitted and there was a review two weeks ago. A lot of the form was filled in and I was asked questions about things on it."

One of the visitors we spoke with felt the care their relative received was very much focussed on their individual needs. They told us how staff had encouraged their relative to become more independent since admission. They told us, "When [person who used the service] first came they had to use a wheelchair at all times but can now mobilise with the oversight of one person".

People told us if they had any concerns they would go to a member of staff. A relative said, "I've had no complaints at all since [person using the service] came here" and "Any problems there is always someone you can go and speak to. Always someone about to ask about anything that arises, but if needed I usually go to the manager and things are sorted".

We found there was no information available to inform people who used the service or their relatives of how they could make a complaint if they needed to, in the home. We looked at how the provider managed complaints and saw that any complaint received was recorded and responded to. The provider told us they had not completed an analysis of the complaints received or of any themes to bring about any improvement that had been identified following a complaint investigation.

Inadequate

Is the service well-led?

Our findings

At the last inspection we found that the provider had failed to seek the views of people who used the service on the quality of the care they received. None of the people we spoke with during this inspection or their relatives could recall being involved in giving feedback on the service or attending any meetings. When asked for their views about the management one relative said, "When we have raised issues they haven't always been sorted out. It doesn't give you confidence in the management". However there had been a survey of people's and relatives views of the service completed during 2014, this was undated but had sought views of some aspects of the service. There was however no evidence of how the issues raised in the survey had been acted upon to continue to make improvements, from the information we looked at or from what the provider told us.

The provider did not demonstrate that there were quality assurance systems in place that could be used to drive forward improvements of the service. We noted there was some evidence of the monitoring of incidents, care delivery and records but these were not consistent. We found examples where peoples' health care needs were not being monitored or addressed to ensure their welfare. There was a lack of oversight or management of their care and a lack of robust systems so as to be able to identify, assess and manage risks to people's welfare.

We saw that although records of accidents and incidents within the home were maintained there was no evidence of an analysis so that any risk to people could be minimised.

At the inspection of May 2014 we identified that staffing levels needed to improve to ensure that people received the care and treatment they needed. At the last inspection of September 2014 the provider had been able to demonstrate an improvement in the staffing numbers and evidence that recruitment of new staff was underway. This included efforts to recruit nursing staff. During this inspection we found that the improvements had not been sustained.

These issues were a continuing breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider informed us that the registered manager no longer worked at the home in May 2014. At the inspection of September 2014 a new manager had been recruited but they have since left we had not received an application for them to register with us. All the staff we spoke with said that the home needed a permanent manager and deputy. They said they felt they lacked the support of experienced senior managers and nurses. Staff said that although the provider was available they did not provide the same type of support as an experienced manager could. Staff were unsure who they were accountable to.

The senior care workers said they had regular supervision sessions from their team leader and they were able to talk about issues of concern. None of the staff we spoke with had received an annual appraisal. We observed the residential care staff had some level of supervision but lacked leadership of a home manager. The nursing staff had no access to have professional supervision or to have their competencies regularly assessed. This meant there was no clinical oversight of their care practice to ensure people's needs were being met appropriately.

Providers of care homes are required to ensure a manager is in post who is registered with CQC to manage the delivery of care.

This was a breach of the conditions of registration Regulation 5 of The Care Quality Commission (Registration) Regulations 2009.

The service was subject to a large scale investigation into allegations of abuse and neglect of people who use the service. The investigation was initiated in response to whistle blowing concerns about the quality of care provided, the safety of people who use the service and staffing levels and competencies. The investigations were not concluded at the time of the inspection as the provider had not been able to demonstrate that all areas of concern had been satisfactorily addressed. The local authority were carrying out regular monitoring visits to the home and reviews of people's care needs had been carried out.

All the staff said they enjoyed their work. One staff member said. "My heart is here". Another said, "It's very nice, lovely atmosphere on the days we have good staff on" and, We're a happy family. The team work is great and we all share problems and all do our best". A third member of staff said, "It can be different when we have got lot of agency staff on" and, "I have always felt welcome from day one. We work as

Inadequate

Is the service well-led?

a team and are there for each other. I have the highest regard for our team leader-she has kept us all going. The mood has been low because of staff situation and stuff going on and all changes in paperwork".

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 5 HSCA 2008 (Regulated Activities) Regulation 2010 Requirement where the service provider is a body other than a partnership How the regulation was not being met: A registered manager was not employed to ensure that people who used the service received appropriate care and treatment.