Malhotra Care Homes Limited

Heatherfield Care Home

Inspection report

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Ratings

Overall rating for this service	Requires improvement
Is the service safe?	**Requires improvement**
Is the service well-led?	**Requires improvement**

Overall summary

We carried out an unannounced comprehensive inspection of this service on 2 February 2015. A breach of legal requirements was found in relations to medicines management. After the comprehensive inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2010 - management of medicines.

We undertook this focused inspection on 7 and 13 August 2015 to check that they had followed their plan and to confirm that they now met legal requirements. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Heatherfield Care Home on our website at www.cqc.org.uk

Heatherfield Care Home provides accommodation and care for up to 74 people. The home is divided into three units for those who have general nursing, dementia nursing and younger physically disabled care needs. Accommodation is spread over two floors. There were 73 people living at the home at the time of the inspection.

We checked medicines management and found improvements had been made. We noted however, that some of the medicines systems which had been introduced had not been fully implemented. One person's allergies had not been documented on her medicines administration record. In addition, protocols for the use of 'as required' medicines such as sedatives were not fully in place. The manager told us that this would be addressed immediately.

Summary of findings

We spent time looking around the home and saw it was clean and well maintained. We found that one person was able to override the restrictor on his window. This risk had not been assessed. The manager told us that this would be addressed.

Some people and staff informed us that more staff would be beneficial. We observed that staff carried out their duties in a calm unhurried manner. Records were not fully available to evidence that safe recruitment procedures were followed. Following our inspection, the manager informed us that recruitment records were now stored in her office.

We did not plan to look at the well-led domain which relates to the management and governance of the service. However, we found concerns which led us to look at aspects of this domain.

The manager had been in post since December 2014 and was not yet registered with CQC. We had rejected her applications to register with CQC in May and August 2015, because they had been incorrectly completed. We have written to the provider to ascertain what actions they are going to take to ensure that an appropriately completed application is submitted to make sure that the manager is registered with CQC in line with legal requirements.

We found that the provider had not notified us of certain events at the service. These included safeguarding concerns, one death and an incident involving the police. In addition, the manager had not notified us of the outcome of Deprivation of Liberty Safeguards applications in a timely manner. She said that she was in the process of completing these notifications.

Following our inspection, the provider promptly submitted retrospective notifications regarding these incidents and events.

We examined falls analysis records which were completed monthly. We found that the number of falls which were documented on the monthly analysis logs did not always tally with the actual number of falls which had occurred at the service. This meant there was no accurate overview of falls in place.

The provider was not able to provide evidence that other incidents, such as certain safeguarding concerns, were monitored and analysed. We were not made aware of these notifiable incidents until staff informed us and we read people's care plans. There was no overview of the number of incidents which had occurred and what actions had been taken. This meant patterns or themes of events involving people who lived at the service could not be readily identified and acted upon.

Following our inspection, the provider submitted a notification to amend their name on our system from Heatherfields to Heatherfield Care Home.

We found one breach of the Care Quality Commission Registration Regulations 2009. This related to the failure to notify us of other events and incidents which had occurred at the service which the provider is legally required to inform us of. This is being followed up and we will report on any action when it is complete.

We also found one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This related to good governance. The action we have asked the provider to take can be found at the back 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?

Not all aspects of the service were safe.

Medicines management had improved. We found that not all medicines systems, which had been introduced following our previous inspection, had been implemented.

Records were not fully available to evidence that safe recruitment procedures were followed. Following our inspection, the manager informed us that recruitment records were now stored in her office.

Some staff told us that more staff would be appreciated. We found that staff carried out their duties in a calm unhurried manner.

Requires improvement

Is the service well-led?

Not all aspects of the service were well-led.

The manager had been in post since December 2014. She was not yet registered with CQC.

We found that the provider had not notified us of certain events at the service in line with legal requirements.

Not all falls were analysed. In addition, there was no evidence that other incidents such as all safeguarding concerns and other events at the home were monitored and analysed.

Requires improvement

Heatherfield Care Home

Detailed findings

Background to this inspection

We undertook an unannounced focused inspection of Heatherfield Care Home on 7 August 2015 and an announced visit on 13 August 2015. This inspection was carried out to check that improvements to meet legal requirements planned by the provider after our comprehensive inspection on 2 February 2015 had been made. We inspected the service against two of the five questions we ask about services: Is the service safe and is the service well-led? This is because the provider was not meeting one legal requirement in relation to the management of medicines. In addition, we found concerns at this inspection with the governance of the service.

The inspection was undertaken by one adult social care inspector and an inspection manager.

We spoke with the manager; two unit managers, two nurses and three care workers.

We spoke with four people and three relatives to find out their opinion of the service. We consulted a safeguarding adults officer, a deprivation of liberty coordinator and a contracts officer from the local authority.

We checked people's medicines records, three people's care plans, one staff member's recruitment records, accident records, notifications, people's daily communication records, safeguarding logs, complaints information and other documents relating to the management of the service. Prior to carrying out the inspection, we reviewed all the information we held about the home.

Requires improvement

Is the service safe?

Our findings

At our last inspection, we found that the provider was in breach of the regulation which relates to medicines management. This meant that people were not fully protected against the risks associated with medicines. At this inspection, we found that improvements had been made; although some systems relating to medicines management, which had been put in place following our inspection, had not been fully implemented.

We checked people's medicines records (MARs) and noted that these were generally completed accurately. The manager told us that medicines allergies were now recorded. We noted however, that one person's allergies had not been documented on her MAR.

We checked whether people's medicines had been administered as prescribed. We examined whether the amount of medicines in stock tallied with the amount of medicines which staff had recorded as being administered. We found that one person's bowel medicine did not tally. The manager informed us that checks were not carried out of people's bowel medicines. She told us that this would be addressed immediately.

A protocol sheet had been introduced to give staff guidance about when 'as required' medicines should be given. We saw however, that this had not been fully implemented. Some 'as required' medicines such as sedatives did not have a protocol in place. The manager informed us that this would be addressed immediately.

We checked the management of controlled medicines at the home. Controlled medicines are medicines that can be misused. Stricter legal controls apply to these medicines to prevent them being obtained illegally or causing harm. There was a system in place to ensure controlled medicines were administered safely.

We spent time looking around the home. We saw that all areas of the home were clean and well maintained. We noticed however, that one person was able to override the window restrictor in his bedroom. There was no risk assessment in place to monitor this risk. The manager told us that this would be addressed.

There were safeguarding policies and procedures in place. People and relatives did not raise any concerns about safety. One relative said, "He's always smiling whenever we see him…It's very, very friendly" and "I think he's safe here. He likes sitting in the lounge, there's always a member of staff in there."

Staff were knowledgeable about the actions they would take if abuse was suspected. During our inspection however, we found that there had been a number of safeguarding incidents. These included altercations between people who used the service. We had not been notified however, of any safeguarding concerns in 2015. This is being followed up and we will report on any action when it is complete.

Following our inspection, the provider promptly submitted retrospective notifications regarding these safeguarding incidents.

We checked staffing levels at the home. Two people and a member of staff informed us that more staff would be beneficial on the younger people's unit especially at night. One person said, "There's only two [staff] and a lot of people need two staff." We spoke with the manager about these comments. She told us that staff were always able to request assistance from staff who worked on other units. She said, "We're not separate units, we work as a team." Another person on the nursing unit felt that there should be more staff. He said, "I wouldn't say there is enough staff. I sometimes have to wait…There's not enough going on."

We observed staff carrying out their duties in a calm unhurried manner. Some people had been out for a trip to a local farm. We spoke with the activities coordinator who said that they had enjoyed their visit. She explained that she worked part time, two days a week and that another activities coordinator was being recruited.

We found that some recruitment records were not readily available for us to check during the inspection. We spoke with the manager about this issue following our inspection. She told us that recruitment records were now kept in her office. We also spoke with the operations manager who said that they used the online Disclosure and Barring Service (DBS) system. She said that a DBS was always obtained before staff commenced employment to ensure that prospective staff were suitable to work with vulnerable people.

Requires improvement

Is the service well-led?

Our findings

Heatherfield Care Home is a purpose built care home which opened in July 2005. The manager had been in post since December 2014 and was not yet registered with CQC. We had rejected her applications to register with CQC in May and August 2015, because they had been incorrectly completed. We have written to the provider to ascertain what actions they are going to take to make sure that an appropriately completed application is submitted to ensure that the manager is registered with CQC in line with legal requirements.

The manager qualified as a psychiatric nurse in 1976. She was no longer registered with the NMC which meant that she could not practise as a nurse. She was previously a care home manager for another provider and worked for a private training company, where she attended University and gained a teaching qualification.

As part of our preparation for the inspection and observations of records, we found that the provider had not notified us of any safeguarding concerns in 2015. In addition we had not been notified of a police incident and there had been a delay in notifying us of the outcome of deprivation of liberty applications. The submission of notifications is important to meet the requirements of the law and enable us to monitor any trends or concerns.

This was a breach of regulation 18 of the Care Quality Commission Registration Regulations 2009. This is being followed up and we will report on any action once it is complete.

Following our inspection, the provider promptly submitted retrospective notifications regarding these incidents and events.

We checked medicines management and found that medicines were monitored differently on each of the units we visited. On the dementia care unit, we found that an audit was carried out of all medicines administered. On the nursing unit we found that not all medicines were checked.

The manager told us that they were going to introduce the same auditing system on each of the three units to make sure that all aspects of medicines management were monitored. In addition, there were still minor shortfalls with medicines recording which we highlighted at our last inspection which had not been identified on the service's medicines audits.

We looked at accident records and noted that these were not always comprehensively completed. Details of what actions had been taken following an accident were not always documented. This omission meant it was not always possible to check that appropriate action had been taken.

We examined falls analysis records which were completed monthly. We found that the number of falls which were documented on the monthly analysis logs did not always tally with the actual number of falls which had occurred at the service. There was no evidence that other incidents such as low level safeguarding concerns and other events at the home were monitored. We were not made aware of some of these notifiable events, which had happened at the home, until either staff informed us, or we read about these in people's care plans. The manager told us that she would speak with the provider about this in case there was a form that she was supposed to be completing and which would aid their monitoring and overview of such events. This meant that the manager was unable to provide us with an overview of all accidents, incidents and events within the home.

This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 [good governance].

Following our inspection, the manager told us that a deputy manager was in place and regular meetings were held to discuss any incidents and accidents at the home and communicate issues which needed to be addressed. She told us, "It's all coming together now, we're working as a team."

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **The provider did not have an effective system in place to assess, monitor and improve the quality and safety of the service.**