Primecare Homes Britannia Limited

Heatherdene Residential 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 effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Overall summary

This inspection took place on 15 June 2015 and was unannounced.

Heatherdene Residential Care Home provides accommodation and personal care for older people and people living with dementia for a maximum of 20. On the day of our inspection 18 people were living in the home.

The home had a registered manager in post who was present for our inspection. 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.

At our previous inspection in May 2014 people's health was compromised by poor hygiene standards within the home. The provider had taken action to address this and an infection prevention and control lead was in place to promote hygiene standards. Cleaning schedules had been put in place to drive improvements but these were

Summary of findings

not always completed to show that the tasks had been carried out. The provider was also required to take action to improve the environment. They sent us an action plan in June 2014. At this inspection we found that not all the required improvements to the environment had been made.

The provider's recruitment procedure was not always followed and this meant that staff may not be suitable to work in the home. The management of medicines was not robust to ensure people received their medicines properly.

People told us that they felt safe living in the home and staff knew how to keep them safe. Staff had access to various risk assessments that told them how to care and support people safely. People told us that they did not have to wait a long time for support and we saw that staff were always nearby to assist them when required.

The manager had limited understanding of the Mental Capacity Act 2005. Where people lacked mental capacity to give consent to their care and treatment, arrangements were not in place to ensure decisions made on their behalf were in their best interests.

People told us that the meals were good but they were not provided with a choice. People told us that they were able to see their GP when needed and they had access to other healthcare professionals when required.

People were not involved in discussions about their care and treatment but they were satisfied with the care and support they received. People told us that staff respected their right to privacy and dignity.

People had limited access to social activities and the provider had not explored people's hobbies and interests or provided support to enable them to pursue this. People told us that they were unaware of the provider's complaint procedures but were confident to share their concerns with staff or the manager.

The provider took no action to address the breach of regulation from our last inspection. The leadership within the home was not effective and staff lacked support and supervision to carry out their roles. People who used the service were not involved in the quality monitoring of it and had no say in how the service was run.

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 safe.

People lived in a home that needed improvement to make sure it was safe for use in some areas. Staff needed to support people more effectively with their medicines. Risk management systems protected people from unsafe care and treatment.

Requires Improvement

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

The manager failed to make sure staff were trained in line with current best practice. People's human rights were not supported because staff failed to recognised when they should take action.

People told us that they enjoyed the meals but they were not provided with a choice.

Requires Improvement

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

People's right to privacy and dignity was compromised because of the environment but staff knew how to maintain their privacy and dignity.

People were unaware of their care plan but were happy with the care and support they received. People were treated with kindness and compassion.

Requires Improvement

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

People's care plans were reviewed but staff did not always have access to up to date information but knew how to care for them. Arrangements were not in place to explore people's hobbies and interests and social activities were limited. People were unaware of the provider's complaint procedure and complaints had not been recorded to show what action had been taken to address them.

Requires Improvement

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

The provider had not addressed all the shortfalls identified at our previous inspection. Leadership within the home needed to be improved in order for the quality of service to improve. Staff were not always supported in their role. Quality assurance monitoring systems in place were not robust to ensure people received a safe and effective service.

Inadequate

Heatherdene Residential Care Home

Detailed findings

Background to this inspection

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

This inspection took place on 15 June 2015 and was unannounced. The inspection team consisted of three inspectors.

As part of our inspection we spoke with the local authority to share information they held about the home. We also looked at our own systems to see if we had received any concerns or compliments about the home. We reviewed information on statutory notifications we had received from the provider. A statutory notification is information about important events which the provider is required to send us by law. We used this information to help us plan our inspection of the home. We also received some information of concern in relation to how the provider managed complaints. We looked at this during our inspection visit.

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.

On the day of our visit we spoke with five people who use the service, one relative, a visitor, two care staff, the cook, an ancillary staff, deputy manager and the manager. We spoke with the provider after our visit. We looked at three care plans, risk assessments, medication administration records, accident reports and quality assurance monitoring audits. We observed care practices and how staff interacted with people.

Requires Improvement

Is the service safe?

Our findings

At our last inspection in May 2014, the provider was in breach of the regulation relating to the safety and suitability of the environment. The provider sent us an action plain in June 2014. They told us plans were in place to refurbish or replace damaged windows.

At this inspection we found that the provider had failed to take action to address the required improvements within the home. One person visiting the home told us, "The building is run down and out of date." One person who used the service described the home as a 'dump.' We saw that restrictors were still not fitted on windows located on the first floor and sash cords from other windows were broken. In one person's bedroom a window restrictor was not in place and the manager said that the person was at potential risk of harm. They told us that they had not taken any action to reduce the risk to the person. We spoke with the provider after our visit who acknowledged that the person was at potential risk of harm. They said that a screen would be fitted to the window to prevent the person accessing the window until the necessary repairs had been done. We saw that radiator covers were missing and left a sharp edge that could cause an injury. The manager was aware of this but told us that they had not taken any action to address this. They told us that these concerns had been shared with the provider but funds had not been made available to do the required improvements. When we spoke with the provider after our visit they confirmed that they had not taken any action to improve the safety of the premises and was unable to give an explanation why.

At our previous inspection cleaning products were not securely stored and placed people at risk of harm. We asked the provider to take action to address this. The provider's action plan did not tell us what they would do to ensure these products were stored safely. At this inspection we found that no improvements had been made. Cleaning products were still not stored in line with guidance. We saw that a portable heater was used in the home and posed a trip and burn hazard to the people who used the service. We saw potential fire hazards such as a curtain disguising a fire door, a desk in a walk way and oxygen stored next to a radiator. We asked the manager why no action had been taken to reduce the risk to people since our last inspection. The manager could not give us any explanation. As a result of these findings we also referred these concerns to the fire safety officer who will carry out an independent inspection.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

At our previous inspection in May 2014, the provider was in breach of the regulation relating to cleanliness and infection control. At this inspection we saw that action had been taken to refurbish the laundry to reduce the risk of cross contamination. For example, we saw clean linen was no longer being stored with soiled and dirty linen. The manager told us they were the infection prevention and control (IPC) lead. This meant they were responsible for maintaining hygiene standards within the home and to put systems in place to reduce the risk of cross infection. We spoke with two out of three staff on duty and they did not know who the lead person for infection prevention was in the home. Staff told us that if they had concerns about hygiene standards within the home they would talk to the manager or the deputy manager. We saw that cleaning schedules had been put in place but they were not always completed to show that cleaning tasks had been carried out and the manager was unable to say whether these tasks had been done. Discussions with the manager and the training records we looked at confirmed that staff had now received infection prevention and control training. Staff told us that they had access to personal protective equipment (PPE) and we saw these located throughout the home and that staff used them when needed. Access to PPE should reduce the risk of cross infection. We saw that the hygiene standards had improved since our previous inspection and saw that communal areas and bedrooms were clean.

The deputy manager told us that two people managed their own medicines but risk assessments in place were not robust to ensure staff knew how to support them to take their medicines safely. The risk assessments did not show what medicines had been prescribed or what the dosage was. One person had been prescribed a medicine to help with their breathing. A staff member who was responsible for the management of medicines did not know how often this medicine should be taken or whether the person had taken them properly. This meant the person may not receive the support required to take their medicine safely. We saw that not all medicines had been stored securely

Requires Improvement

Is the service safe?

and were accessible to people and this placed them at potential risk of harm. We spoke with the provider after the inspection who said they would take action to ensure all medicines were securely stored. We looked at two medication administration records (MAR) and found that they had not been signed by staff to show that people had received their medicine. However, we found out that these people had received their medicines and staff had failed to sign the MAR. The MAR showed that some people had been prescribed 'when required' medicines that should only be given when required. Staff told us that they had access to a written protocol that told them how to manage these medicines safely and they were aware of when these medicines should be given.

The manager told us that they were aware of the provider's recruitment procedure. The manager told us that they had not adhered to this when they appointed one staff member. They told us that despite knowing the procedure they had employed a member of staff without references or other required safety checks. The manager said they were desperate to recruit quickly. They acknowledged that this placed people at risk of potential harm. We spoke with the provider after our visit who told us that all staff should have the appropriate safety checks before they start working at the home. They told us that they were unaware that the manager had not followed the appropriate procedure to safeguard people. The manager assured us that the provider's recruitment procedure had been followed for other staff and this was confirmed by the staff we spoke with. We looked at a staff file and saw that the appropriate safety checks had been carried out. People told us that staff were always around when they needed them. One person who used the service said, "I've used the call bell and they come quickly." The manager and staff told us that there were enough staff on duty to meet people's needs. On the day of our visit we saw three care staff and one ancillary staff on duty and saw that staff were nearby to support people when needed.

Staff told us they had access to risk assessments that told them how to safely support people. We saw falls risk assessments that told staff how to reduce the risk of people falling and equipment required to support them with their mobility. We saw people using the equipment as identified in their care records. Accidents had been recorded and monitored to find out if there were any trends and where necessary action had been taken to reduce the risk of this happening again. For example, the GP would be contacted to identify if falls were due to a medical reason. The care records we looked at showed that consideration had been given for a referral to a falls clinic. Records did not show any other form of accidents in the home.

People told us that they felt safe living at the home. One person said, "It's very good here, I do feel safe." Another person said, "I can't say they make me feel safe but I manage anyway." Staff told us that they were aware of how to protect people from the risk of potential harm. They were aware of various forms of abuse but did not recognise that the unsafe premises placed people at risk of harm. Staff told us that they would share any concerns of abuse with the manager and if this was not acted on they would use the whistleblowing procedure. We saw that incident forms had been completed where they had been a safeguarding concern and that the manager had shared concerns with the local authority to protect people from further harm.

Requires Improvement

Is the service effective?

Our findings

The manager told us that a number of people who used the service lacked mental capacity to consent to their care and treatment but we heard staff ask people for their consent before they assisted them with their care needs and people responded to this. The manager was unaware of when a mental capacity assessment should be carried out and told us that there were no assessments in place. One care record showed that the person had mental health needs and was confused and the manager confirmed this. Records showed that the person's was moved from a single occupancy bedroom to a shared bedroom. The manager was unable to tell us how this decision had been made and if it was in the person's best interest. There was no evidence that the changes to the person's living arrangement had been discussed and agreed with them. Due to the person's mental health needs they were unable to tell us if this was their choice. The manager said that a best interest decision had not been made on behalf of this person. The manager told us that best interest meetings were carried out with relevant parties to ensure decisions made on behalf of people were in their best interest. The manager was unable to provide evidence of these meetings.

This was in breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

A visiting professional told us, "Staff do not have enough knowledge about MCA and DoLS." The manager and staff told us that people would be restricted from leaving the home because this would place them at risk of harm. The manager was unaware of when it would be necessary to apply for a Deprivation of Liberty (DoL). The manager confirmed that no consideration had been given to complete an application for a DoL and that these were not in place. A staff member told us that they were undertaking a dementia awareness course and now recognised that some people's liberty had been restricted. They told us that they had discussed with the manager the need for MCA assessments and a DoL where restrictions were in place for people but no action had been taken. This meant there was a risk of people's human rights not being supported as required by the law.

The manager told us they delivered necessary training to the staff in order to support them in MCA and DoLS but they were unable to tell us what this meant in terms of supporting people's right to make choices and when restrictions may need to be placed upon their liberty. Staff told us they had learnt about MCA and DoLS from other sources and not the manager.

The manager told us that the provider's recruitment procedure included an induction. One person who used the service said that the staff knew how to care for them and told us, "They are good, you couldn't ask for better staff." We spoke with a staff member who had recently started work at the home. They told us that they had not received an induction or training and was unaware of their roles and responsibilities. We saw that the new staff member's practices were unsafe where cleaning chemicals were left unattended which placed people at potential risk of harm. The manager confirmed that unsafe practices could be due to the person not receiving the appropriate training or support. The manager was unable to say why the staff member had not been provided with training or an induction into their new role. The manager assured us that all the other staff had received an induction and training and this was confirmed by two staff we spoke with. One staff member told us that they had received training in moving and handling, safeguarding, management of medicines and infection control. We spoke with the provider after our visit who said that they were unaware that the new staff had not been provided with the appropriate support and said this would be addressed with the manager.

The manager told us that not all staff received supervision because they worked from 8am until 4pm and were not available to supervise the night staff. The Provider Information Return stated, 'Staff supervision has always been a little hit and miss.' One staff member told us that not receiving supervision made them feel devalued. We spoke with a care staff who worked during the day time who confirmed that they had received supervision. The provider told us that the manager had a duty to ensure that all the staff team received supervision and was unaware that this was not happening.

This was in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

People told us that the meals were good but they were not provided with a choice. We saw a menu board displayed in the home and this did not provide a choice of meals and the manager acknowledged this. We heard one person refuse their lunch because they didn't want sausages and

Requires Improvement

Is the service effective?

an alternative was not offered until we spoke with the cook. A person told us that whilst visiting the home they heard one person refuse their lunch and they asked for Weetabix. They told us that this was not made available to them and they saw that the person did not have anything to eat that lunch time. This meant that people may not always be provided with meals they liked.

We saw that where people required support to eat and drink, staff assisted them in a caring and dignified manner. We heard a person say, "I could do with a drink of tea," and this was promptly provided to them. People told us that they had access to drinks at all times and during our visit we saw staff offering people drinks. Where concerns were identified that people did not eat or drink enough we saw charts in place to monitor this. Discussions with staff and the care records we looked at confirmed that people did have access to a speech and language therapist (SALT) and a dietician when needed.

People told us that they were able to see a GP when needed and the care records showed that they had access to other healthcare professionals when required. One person said, "I've seen the doctor and now I am waiting to see the optician." This meant that people could be assured that their healthcare needs would be met. We spoke with two care staff who were aware of people's care and support needs and how to meet them.

Requires Improvement

Is the service caring?

Our findings

We saw that there were no privacy locks on bathroom doors and that some bedrooms and a toilet did not have any privacy screening at the windows. The manager told us that curtains had been removed during the weekend to be laundered and no alternative arrangements were in place to ensure people's privacy. The manager's work station was located in the main corridor and we saw that confidential records were accessible to anyone who accessed the home. One person's bedroom was cluttered with wheelchairs and a hoist. The manager told us that some of the equipment did not belong to the person. This showed a lack of respect for the person's personal space.

People told us that staff did respect their privacy and dignity. One person said, "The staff call me by my name." Another person told us, "The staff knock on my bedroom door before they enter." Staff were aware of their duty of promoting people's rights to privacy and dignity. We saw that people were supported with their personal care needs in a private area. One staff member told us that whilst they supported people with their personal care needs they gave them a choice to carry out some tasks alone to maintain their privacy and dignity.

The manager told us that people were involved in planning their care but was unable to provide evidence of this.

People we spoke with were unaware of their care plan but said they were happy with the support they had received. One relative told us that they had provided staff with information relating to their relative's care needs and was happy with the support they had received. Staff told us that they had access to care plans and were aware of people's needs and how to meet them. One person required staff to reposition them whilst in bed as part of their pressure care treatment. Staff were aware of the support this person required and told us what equipment was in place to prevent further skin damage.

We saw staff treat people with kindness and compassion. One person said, "The staff are caring." We spoke with a person visiting the home who told us that, "The home is warm and comfortable and people seem happy." They told us that staff were caring. We spoke with a relative who described staff as "Very good, sensitive and understanding." We heard staff talk with people in a kind and caring manner and were responsive to their needs. A staff member told us that when they supported people with their personal care, they made sure that they were comfortable and found out their likes and dislikes. We saw a staff member support a person with their mobility and heard them explain to the person what they were doing; they guided them and reassured them through the process.

Requires Improvement

Is the service responsive?

Our findings

We saw people sat in their armchairs watching television and some had fallen asleep. We saw another person reading the newspaper and one person had completed a puzzle book. One person said, "Sometimes I paint." Another person told us that, "Sometimes I throw a ball." One person said before they moved into the home they use to enjoy doing things in the garden but the home didn't have a garden. A person visiting the home told us, "There is a lack of stimulation provided to people." One person who used the service said, "I am fed up and want to pass on." The Provider Information Return showed that people's interests would be identified and that they would be supported to continue with this. We found that people's interests and hobbies had not been explored or arrangements put in place to support people to pursue this. A board located in the reception area told people about forthcoming entertainments. The manager told us that church services were carried out in the home and people were able to attend if they wished but one person said, "Someone visits from the catholic church but I am Methodist." This meant that people's diverse religious needs were not catered for. People told us that staff did listen to them but one person expressed the lack of stimulation and access to their local community. They told us that they were reliant on their friend to take them out. A person visiting the home said, "I could think of better places to live, there is not enough stimulation." One care staff said that social activities consisted of skittles, throwing a ball, dominoes and sometimes people were supported to go shopping.

People's care plans were reviewed by the manager to reflect their changing needs but staff did not always have access to up to date information because the manager had not made them accessible. The staff we spoke with were aware of people's needs and how to meet them but not of any recent changes because the manager had not informed them of the recent changes to people's plans.

The home provided a service for people living with dementia and the manager told us that two staff were undertaking dementia awareness training and one staff member confirmed this. We saw that information to assist people living with dementia was not up to date. For example, we saw information to help remind people of the day and date provided incorrect information. We heard three people discussing this and were confused to what date it was. Additionally information about the menu and the meal that was on offer did not reflect the meal people were given. The manager acknowledged that there was a delay in updating the board and the confusion this may cause people living with dementia.

People were unaware of the provider's complaint procedure but told us that they would share any concerns with staff or the manager and were confident that this would be dealt with. We saw the provider's complaint procedure located in the reception area and this told people how and who to share their concerns with. There were no arrangements in place to support people living with dementia to share their concerns with the provider. The provider did not have the complaints procedure available in different formats at the time of our inspection. After our visit the provider told us that the complaints procedure was available in different formats so people could understand it. The manager told us that they had not received any complaints. We received information of concern about the service in relation to the poor cleanliness and hygiene standards within the home and an allegation that people's personal care needs were not being met. We shared these concerns with the provider. The manager acknowledged that these concerns had not been recorded to show what action had been taken to address them. The manager assured us that action had been taken to resolve the concerns.

Inadequate

Is the service well-led?

Our findings

The manager and the provider confirmed that no action had been taken to address the breach of regulation identified at our previous inspection in May 2014. The manager told us that the premises were unsafe but the provider had not provided funds to enable them to address this. The provider was unable to say why they had not taken any action to address the concerns despite including this in their action plan in June 2014.

The provider had a system in place for checking the quality of the service provision within the home. However, we found that this system was ineffective and failed to identify areas where improvements were needed. The manager told us that the provider visited the home on a regular basis and we saw the reports of these visits. The reports did not identify the shortfalls in service provision we had found. There were a number of checks in place that should identify areas for improvement in the service. These included checks of cleaning schedules, medicines and people's care plans but these were not always signed to show that the task had been carried out. We saw that systems in place to support people in the event of a fire were not robust. We saw that furnishings obstructed a main route of escape and that a fire door was not visible because a curtain had been fitted to the door. This placed people who used the service at risk of harm.

The manager was unaware of their responsibility to have an effective system in place that made sure all staff were appropriately supervised and supported to carry out their role. The manager acknowledged that a new staff member had not been appropriately supported into their new role. They confirmed that the lack of support provided to this staff member placed people who used the service at potential risk of harm. We saw that young people on a work experience placement from the local college had not been provided with supervision and the manager acknowledged this. We saw that this placed people at potential risk of harm, when the manner in which a person was supported with their meal placed them at risk of choking. We spoke with the provider after our inspection who told us they were unaware staff were not provided with the relevant support to carry out their role safely. They told us that young people from the local college should be closely supervised and said this would be addressed with the manager.

Discussions with the manager confirmed that they were aware of when to inform us of incidents that had occurred in the home and knew when to share concerns of abuse with the relevant agencies. The manager was aware of when to send us a statutory notification to tell us about important events which they are required to do by law.

Staff told us that they were not always comfortable to share information with the manager and found the deputy manager more approachable. When we informed the manager of the feedback we had obtained from staff they were unhappy that this information had been shared with us and said this would be addressed with staff with regards to their conduct. This meant that there was not an open culture where staff views were listened to and taken seriously.

The manager lacked understanding of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) and when these should be applied. The provider told us that the manager was qualified to deliver MCA and DoLS training to the staff team. They confirmed that they had not assessed the manager's understanding of MCA and DoLS to ensure that they had the skills and competence to deliver this training. They were also unaware that the principles of MCA and DoLS had not been applied in the home.

The manager told us that meetings were carried out with people to find out if they were happy with the service they had received and we saw evidence of this. A meeting was carried out in March 2015 and discussions took place regarding the redecorating of the home but this did not provide a timescale of when this would be done. The minutes showed that people had requested a pet budgie and saw that this had been provided. We saw that the previous meeting with people who used the service was carried out in May 2014; this meant people had limited opportunity to tell the provider about their experience of using the service. The manager told us that staff meetings were carried out and this was confirmed by a staff member.

This was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12(d) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014. Arrangements were not in place to ensure that the premises used by the service provider are safe to use for their intended purpose and are used in a safe way.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014. Arrangements were not in place to support people who lacked capacity to give consent to their care and treatment. Best interests meetings were not carried out to ensure decisions made on behalf of people were in their best interest.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014. The provider did not ensure that all staff employed were competent and skilled or that staff received suitable training, supervision and induction.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance

This section is primarily information for the provider

Action we have told the provider to take

Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

The provider did not have robust systems and processes in place to assess, monitor and improve the quality and safety of the services provided in carrying on of the regulated activity.