Orchard Care Homes.com (3) Limited

Heartlands

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**

Overall summary

This inspection took place on the 25 and 26 November 2015 and was unannounced.

We last inspected Heartlands on the 26 and 27 February 2015 where we found the provider had breached the Health and Social Care Act 2008 in two regulations. The provider sent us an action plan detailing the improvements they would make.

This was a planned comprehensive inspection that would have inspected the service under the five domains of Safe, Effective, Caring, Responsive and Well led. When we arrived, we were told by a representative of the organisation that the provider was in the process of selling Heartlands, which was subject to contract, with a possible date for the contracts be exchanged. As there would have been a change in the legal status of ownership of Heartlands, we changed our inspection to a focused inspection, looking at whether the service was Safe and Effective. Therefore, this report only covers the findings under Safe and Effective and in relation to the breaches; with regard to care and treatment being provided in a safe way and with the people's consent. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Heartlands on our website at www.cqc.org.uk.

Heartlands is registered to provide accommodation and nursing care to up to 76 people. The home is purpose built and divided into four separate units across two floors. Broadstone and Yardley on the ground floor and Dovecote and Osbourne on the first floor. The home has a second floor that is not in use. Three of the four units provide nursing care to people with a form of advanced dementia and / or other health conditions. The fourth unit provides personal care, without nursing, to people suffering from mild to moderate dementia. On the day of our visits we were told there were 64 people living at the home.

Summary of findings

The registered manager had recently resigned. 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. There was an acting manager, who at the time of this inspection, had been in the post for eight days. The acting manager has submitted their application to the Care Quality Commission to become the new registered manager. The acting manager was also being supported by an independent consultant.

There had been some improvements made to the safe way treatment and care was being provided to people. However, we observed that further improvements were needed in all four units to ensure people's needs were well met.

There had been some improvement in the medicine management practices at the home; however there was still room for improvement.

Staff understood their responsibility to take action to protect people from the risk of abuse and harm because the provider had systems in place to minimise the risk of abuse. However, we saw that staff did not always follow the assessments to minimise the risks associated with people's care and this put people at further risk of injury. You can see what action we told the provider to take at the back of the full version of the report.

Referrals for people requiring support from other health care professionals; were not always made in a timely way to ensure risks to people were minimised.

The provider had not always recognised when the care being offered had put restrictions on people's ability to choose and move around freely. Restricting people's freedom to move around without the necessary authorisation meant that the provider was not meeting the requirements of the Mental Capacity Act and Deprivation of Liberty Safeguards. Therefore people's human rights were not always protected. You can see what action we told the provider to take at the back of the full version of the report.

Staff knew about people's needs but this was not consistent across the four units. Staff had received training but this had been ineffective to enable them to deliver care safely and effectively.

People were not always supported in a timely manner. Staff deployment was not sufficiently effective to ensure that people were adequately supervised, so that their care needs were met in the way people preferred.

People who needed support to eat and drink to prevent the risk of poor nutrition and dehydration had not always received this support effectively. People felt staff that supported them were caring and kind and they felt safe with staff.

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 consistently safe

People were not consistently protected from the risk of harm because staff was not always aware of the processes they needed to follow.

Because the deployment of staff was not at all times efficient, support for people was not constantly provided in a timely way.

People received their medicines as prescribed, although improvement was still required to the management and recording of medicines.

People felt safe with the staff that supported them.

Is the service effective?

Requires improvement

The service was not consistently effective

Peoples' nutritional needs were assessed and monitored to identify any risks associated with nutrition and hydration; but these were not always effective as staff did not consistently follow guidance as required.

Peoples' rights were not consistently protected. Staff did not understand the legal principles to ensure that people were not unlawfully restricted so care was not always provided in people's best interests.

People did not consistently receive effective support. Staff did not always recognise when to request the involvement from other healthcare professionals where necessary.

People felt they were supported by staff that knew them.

Heartlands

Detailed findings

Background to this inspection

We carried out this focused 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 unannounced inspection took place on 25 and 26 November 2015. This was in response to a series of concerns that had been raised by other agencies with the Care Quality Commission. We wanted to check that improvements and action had been taken in line with the provider's action plan in response to issues raised from a previous inspection on 26 and 27 February 2015. This related to two of the five questions we ask about the service. Is the service safe? Is the service effective?

The inspection was conducted by two inspectors, a pharmacy inspector, bank inspector, an expert by experience and a specialist advisor. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of dementia care service. The specialist advisor had an in-depth knowledge in nursing care. Two trainee inspectors were also present as part of their post induction training programme.

We looked at the information we held about the service. This included notifications received from the provider about deaths, accidents/incidents and safeguarding alerts which they are required to send us by law. We looked at information received from other local agencies and used this information as part of our inspection process.

During our inspection we visited all four units and spoke with 13 people who lived at the home, five relatives, eight nursing and care staff, the acting manager and the independent consultant. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We reviewed the care plans of seven people, 16 people's medicine administration records to see how their care was planned and looked at. We also looked at records which supported the provider to monitor staffing levels and staff training to see if they were effective and up to date.

Requires improvement

Is the service safe?

Our findings

When we inspected Heartlands on 26 and 27 February 2015, we found that the arrangements in place to protect people against the risks associated with the unsafe use and management of medicines were insufficient. This was a breach of Regulation 12(f)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We asked the provider to submit an action plan that was received in August 2015. We spent time reviewing the general medicine management systems in place, as well as the Medicine Administration Records (MAR) charts for 16 people on three units (Dovecote, Yardley and Broadstone). We acknowledged that some practices were improving however we found that safe medicine management systems were still not fully in place.

We found that checks were being undertaken by the service to ensure people's medicines were given as prescribed. However, where issues with medicine management were identified there were no action plans available to show what improvements or learning points were to be made.

Overall, we found that the MAR charts were well documented to show that people had been given their prescribed medicines. People we spoke with, who were able to tell us, said they received their medicines as prescribed by their GP. We saw that appropriate arrangements were in place to ensure that accurate stock checks could be undertaken. This also included records of running stock balances of medicines. In particular we looked at the MAR chart for one person prescribed a medicine that needed to be carefully monitored in order to make sure that they were given a safe dose. We were able to check that the correct dose had been given because the service documented the date of receipt, the quantities available and recorded the date of opening of the medicine container.

We found one medicine in the medicine trolley labelled for a person which was not written on their current MAR chart. The medicine was to be used when required for an angina attack. On informing a nurse we were told that they must have missed it off because it had not been used. However, this meant that there was a potential risk for the medicine not to be given because it was not recorded as available on the MAR chart.

When a person was not given a medicine the reason for not giving the medicine was not always recorded. In particular we noted that a code 'O' was often recorded when a medicine was not given. However, the specific reason for not giving the medicine was not documented. This had not been identified by the checks made by the service. This is important information to record so that the person's doctor can assess if the medicine is required or what further clinical decision can be taken.

When people were prescribed a medicine patch to be applied to the skin we found that the site of application on the person's body was not always recorded. This would enable nursing staff to know where to locate and remove the old patch before replacing with a new patch. This is particularly important for people prescribed pain relief skin patches to ensure they have adequate pain relief.

Supporting information, when people were prescribed a medicine to be given 'when necessary or when required', was not always person centred. We looked at three people prescribed a medicine to be given when required for anxiety or agitation. There was no information to support staff to explain under what specific circumstances the medicine should be given. This information is useful to help support nursing staff who might not be familiar with a person in making a professional decision whether a person requires the prescribed medicine.

Documentation for the administration of medicines to people who lacked capacity to make an informed decision was not kept up to date. We looked at two people whose records stated they were being given their medicines concealed in food or drink. There were no records of best interest meetings which detailed who had been present and how the decision had been made to give medicines hidden in food or drink. It was also not possible to know from the MAR charts how the medicines were to be given to the person safely.

Controlled drugs (CD) records were not accurate at the time of the inspection. Controlled drugs are medicines that need to have extra storage and recording arrangements in place for safety. We found that one CD balance was not accurate despite the daily checks that were in place. On informing the nurse in charge we were told that the checks had been made on handover and were accurate. They were unable to explain why the balance for one CD record was not correct. The nurse undertook an investigation and informed us that

Is the service safe?

an accidental error had occurred on handover of the shift. The CD medicine was located and returned to the CD storage cupboard. The service agreed to undertake a full investigation to ensure the error did not occur again.

All medicines were stored securely and within the recommended temperature ranges. Sufficient quantities of people's medicines were available to ensure that people's healthcare needs were being met.

We spent time on all four units and talked to people, relatives and staff members. People we spoke with told us they felt safe and if they were concerned about anything they would speak to the staff. One person we spoke with said, "Yes, I feel safe here." A relative told us, "I've never seen anything to cause concern." We saw that some people were at risk of sore skin and required the support of pressure relieving equipment. We checked the care plans of one person and established a risk assessment had been completed. We saw from the person's care plan, a specific cream was to be applied as a preventative measure. However when we spoke with staff, they were unaware that the cream should be applied at regular intervals to prevent a break down in the person's skin. This put the person at risk of further soreness to their skin. The nurse told us that pressure relieving equipment was not individualised and that communal pressure relieving equipment was used. The nurse said, "Everyone uses everyone else's, it's what people have left behind when they have left." The person's risk assessment said that a pressure cushion should be used at all times while sitting, however throughout our inspection, the person did not use a cushion and when we asked staff, they told us that they were not aware that the person used a pressure cushion. Staff told us that all equipment, such as walking frames and pressure relieving equipment was communal and no individual person had been assessed. We raised this with the acting manager and consultant. They told us they would ensure people were referred to the appropriate health care professional for assessment, so they would have their own pressure relieving equipment.

People were not always encouraged to walk around the home, one person we spoke with told us, "I just sit here, and I would like to walk around more." Another person said, "I only get out of this chair when staff take me to the bathroom." We saw that people who required the support of walking frames, did not always have them to hand. One person's risk assessment had stated the person should always have their walking frame close by. We spoke with the nurse and asked them where the equipment was for the person and they told us this was in the person's bedroom. The nurse said that she had not realised that the person was not using it. We saw that people were given "communal" walking frames that had not been specifically measured to the individual so the person was at risk of falling because walking frames are available in different heights and should be assessed for the individual person to meet their specific walking needs.

Although the staff we spoke with described what action they would take to keep people safe from the risk of harm. We saw from records that risk assessments had not always been appropriately assessed and followed. Information contained within the files was not always accurate and up to date. For example, we saw that on one person's care plan, had been identified they required "sensible shoes" because they walked around their environment for a large part of the day. During our inspection we saw the person was walking in soft, unsupported slippers. Their relative told us, "We have asked staff to make sure [person's name] has their sandals on, they get blisters and sore feet if they don't." We saw from the person's care plan that blisters had developed. We raised this with the acting manager and consultant. They told us they would make sure the person's support would be reviewed and a referral would be made to the appropriate health care professional.

People were being put at risk because the provider had failed to safely and effectively assess the risks to people's health and safety that could impact receiving care and treatment in a safe way. This was a breach of Regulation 12 Health and Social Care Act 2008 (Regulated Activities) 2014.

People and relatives spoken with felt there could be more staff available to support people. One person told us, "No there is not enough staff." Another person said, "You don't see much of them [staff], there isn't enough staff, most of them are rude anyway so I can't say if they are good." We spoke with the acting manager about staff that had been identified as not meeting the standards expected by the provider and were told they no longer worked for the service. A relative said, "There isn't enough staff." Another relative told us, "I've been here on my own with no staff about and some residents try to stand up when they shouldn't because they can't walk." Two of the staff we spoke with felt there could be "one or two" extra members of staff required. For example, when a person was admitted

Requires improvement

Is the service safe?

that required more one to one support, some staff felt this was not always reflected in the deployment of staff numbers. They told us this would put staff under additional 'stress' when attending to the individual needs of people which could put others at risk because they might have to wait until the staff were finished. We saw that staff was busy although this was not always with supporting people around the home. People were left sitting at dining tables for long periods of time waiting to be taken through to the lounge. This put one person at risk of further soreness to their skin as they did not have the appropriate pressure relieving cushion on their chair. Arrangements in place to determine safe staffing levels had not been effective. We saw that people were not always cared for in a timely manner and in a way that met their needs. Some people who remained in their rooms were left waiting for their meals for up to 35 minutes. This was after the meal trolley was brought to the unit where staff would 'plate up' lunch for people. We saw staff had to explain to people they would have to wait until they had finished supporting other people. This demonstrated that at lunch time, there was insufficient staff to support people to eat. We discussed how staffing numbers were determined with the acting manager and consultant. They felt the issue of staffing related to the deployment of staff rather than a lack of staff. This was an area the acting manager was looking to address immediately.

The provider had a recruitment policy in place and staff told us they had been appropriately recruited. Staff said they had completed a range of pre-employment checks before working unsupervised.

We asked staff how they would identify if people were at risk of harm or abuse. One staff member said, "If someone was upset, I would try to calm them down, I would use a talking technique." Another staff member told us, "If someone had fallen, I would check them for injury and make them comfortable then call for the nurse." Staff told us they had received safeguarding training and were knowledgeable in recognising signs of potential abuse and how to follow the provider's safeguarding procedures. Staff knew how to escalate concerns about people's safety to the provider and other external agencies for example, the local authority and Care Quality Commission.

Requires improvement

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

When we inspected on the 26 and 27 February 2015, we found the processes the provider had in place to make sure people received care, only where they had provided consent or where this was in the person's best interest, were not effective. The provider had not submitted any DoL applications to the Supervisory Body. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We asked the provider to submit an action plan. We found that although DoL applications had since been submitted to the Supervisory Body, there were improvements to be made to the provider's process of mental capacity assessments.

Staff told us that they had received training in the MCA and explained the importance that people made their own decisions. We saw staff cared for people but not always in a way that involved them in making choices and decisions about their support. We heard some staff ask people what they wanted to do and other staff worked in a task led way rather than a person centred way. For example, we saw that some staff supported people to make a choice about what they wanted to eat and drink; although this was not consistent in all units. One person told us, "I broke my hip and find it easier and less painful to remain in bed but the staff keep telling me sit in a chair which is very painful." This was not effective because there was no pain management plan in place on the person's care plan and staff did not always carry out the person's care how they had requested it.

We saw from two care plans, the provider had not understood the legal requirements to submit an emergency DoL application. These applications should be submitted within seven days of a person's admission, should they be assessed to lack the mental capacity to make decisions, about their care and support. One person had their application submitted four weeks after their arrival. With regard to a second person, the provider had failed to recognise they were depriving the person of their liberty. No application had been made; therefore the person's rights were not being protected in line with current legislation. We found that people had been subjected to a level of restraint and being deprived of their liberty. The staff and acting manager had not recognised this. We spoke with the acting manager and consultant; they explained that they would make sure the necessary application would be submitted to the Supervisory Body.

We found the provider had not ensured staff providing care and treatment had the skills to do so effectively. This put people at risk of being deprived of their liberty and receiving inappropriate care. This was a breach of Regulation 13(5) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were 25 people who had 'do not resuscitate' requests in place. In the care plans we looked at, we found no evidence to show best interest meetings had taken place, for those that had been assessed to lack mental capacity. We were told by one staff member they were unaware which people had 'do not resuscitate' requests in place. This could result in unnecessary medical treatment being administered, against a person's wishes or not in their best interest, in the event of an emergency.

In the dining areas within the four units, there was a relaxed atmosphere and people were not rushed. People chose their meals in advance; however, a number of people we spoke with could not remember what they had ordered. The choice of meals was displayed on notice boards. Staff did not always inform people what was for lunch or on their plate when they supported people to eat. However, we saw one person had told staff they did not want the dinner and they were given an alternative. We saw staff provided assistance to people that required support to eat, although we saw two staff members 'blowing' on people's meals to cool them down. This put the two people at risk of infection because their food could become contaminated with bacteria emitted from the staff member.

Requires improvement

Is the service effective?

People were largely complimentary about the food. One person said, "The food is lovely, you always get plenty to eat." Another person told us, "The food is alright." Lunch looked appetising and was presented to people in an appealing way. Peoples' dietary needs were catered for and supplements were used for those who were at risk of losing weight. People's weight, food and fluid intake was monitored although this was not always effective. We saw where one person's weight had started to drop; the staff had failed to act upon the instructions of a hospital letter stating the person should be weighed weekly. This had not happened and there was a significant weight loss over a short period of time. We discussed this with the acting manager and the consultant. They told us this would be urgently reviewed and the scales checked for their accuracy. People were offered drinks throughout the day although some people in their rooms did not have access to drinks. This was raised with staff and drinks were taken to people in their rooms.

There was a mixture of opinions from people and relatives about the skills of staff. Some people felt staff knew them and were knowledgeable and that staff were trained to support them. One person told us, "The staff are very kind and helpful." Another person said, "The staff are okay." A third person told us, "Most are ok." A relative told us, "I've no complaints." Another relative said, "Sometimes I don't like the staff attitude." Discussions we had with some of the staff demonstrated to us, they had a good understanding of people's needs; whilst other staff did not. One staff member we spoke with told us, "I have been here a long time and know the residents very well." Another staff member was not able to explain what was contained within a person's care plan that they were supporting. We saw that care plans were in place to support staff. Although all the care plans we looked at contained inconsistencies around people's individual care needs. There was some effective guidance for staff, for example, one care plan had a detailed reposition chart. This chart gave staff the information they needed to know, in order to support the person to prevent damaged skin. However, another care plan did not contain a reposition chart, despite the person being at risk of soreness to the skin. Staff we spoke with did not always know when people required repositioning to prevent soreness to their skin. This inconsistency in staff knowledge and the information contained within people's care plans, left people at risk of not receiving consistent care and support. We discussed this with the acting manager and consultant, they confirmed the discrepancies had already been identified and they were working with staff to address them.

Although staff told us they had completed moving and handling training, this was not effective. We saw some staff were unfamiliar with, and lacked confidence when using, the hoisting equipment. For example, one staff member did not know which button to press to move the equipment. A relative told us, "I have seen unsafe practice when staff heave residents from their chairs into wheelchairs." Staff we spoke with told us they used "communal slings" that attached to the hoists, which supported people to stand before being moved. This put people at risk of falling because slings are available in different sizes and should be assessed for the person being supported, so as to meet their individual's needs. We discussed this with the acting manager and the consultant. They told us that they were currently reviewing all the training needs of staff and had ordered a number of different sized slings. We found that the acting manager and consultant was open and transparent about where improvements had to be made.

Staff told us they had received training to support them in their role. One staff member said "I feel confident in my job." Another staff member told us, "The training tends to be on-line and we can do it here if we have the time, but mostly I do mine at home." The acting manager explained to us that as part of the redevelopment of the service in preparation for the sale of the home, they were also reviewing how training should be delivered to staff. There was a difference of opinion amongst the staff we spoke with around their supervision. One staff member said, "I haven't had any formal supervision but I can always go to the senior or manager if I needed to." Another staff member told us, "I have had supervision but can't recall when." The acting manager told us they had identified that some staff had not received supervision and this was currently being arranged.

We saw from people's care plans they had access to health care professionals, as required, so that their health care needs were met. Although this was not consistent and we found there had been delays in contacting other health care professionals. Four of the seven care plans we looked at required referrals to be made to the Occupational Therapist for specialist equipment. The delays in making these referrals had put two of the people at risk of further

Requires improvement

Is the service effective?

soreness to their skin. There were a number of people who required the support of walking frames and wheelchairs. Staff confirmed to us no referrals had been made for equipment. This was not effective as walking frames and wheelchairs should be assessed for the individual to make sure they accommodate the person's size, ability and support. People using frames and wheelchairs that are not specifically assessed for them, could lead to falls and injury due to incorrect posture. We discussed this with the acting manager and consultant. They confirmed the use of communal equipment had already identified as an issue. The acting manager was in the process of reviewing people's care plans and needs.

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 People who use services and others must receive care and treatment in a safe way. Regulation 12 (1)(a)(b)(c)(e)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment A person must not be deprived of their liberty for the purpose of receiving care or treatment without lawful authority. Regulation 13(5)