Heanton Limited

Heanton Nursing Home

Inspection report

Heanton
Barnstaple
Devon
EX31 4DJ

Tel: 01271813744

Date of inspection visit:
13 March 2018

Date of publication:
09 April 2018

Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

This inspection was a focussed inspection which took place on 13 March 2018 and was unannounced.

We completed this inspection to check on the welfare and safety of people following an incident where one person had swallowed a harmful substance. We wanted to ensure this type of incident could not occur again and lessons had been learnt. We had also been made aware by the provider that one person had sustained an injury following a fall from their wheelchair. We wanted to check that people had up to date risk assessments and where appropriate staff were using a lap belt on wheelchairs to help prevent people falling out of them.

The team inspected the service against two of the five questions we ask about services: is the service well led and is the service safe? This report only covers our findings in relation to this topic. You can read the report from out last comprehensive inspection, by selecting the 'all reports' link for Heanton on our website at www.cqc.org.uk

No risks, concerns or significant improvement were identified in the remaining Key Questions through our ongoing monitoring or during our inspection activity so we did not inspect them. The ratings from the previous comprehensive inspection for these Key Questions were included in calculating the overall rating in this inspection.

When we last inspected the service in April 2017 we focussed on one key question- Safe. This was because we had received some information of concern via the local safeguarding team. This information related to issues relating to infection control practices, people's care needs not being met, staff attitude, lack of respect and dignity and people being placed at risk from lack of hygiene and continence support. None of the concerns raised to the Local Authority Safeguarding Team were upheld. We observed people being treated with respect, dignity and the staff observed were caring and compassionate on the day we inspected. We did still rate this key question as requires improvement because we observed some key times in specific areas where there may not have been enough staff to meet people's needs. We made a recommendation for the service to review the deployment of staff which they responded to. They reduced the number of staff taking breaks together so staffing levels remained consistent throughout the day.

Heanton is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Heanton is registered to provide care support and treatment for up to 52 people. At the time of this inspection there were 47 people living at the service.

They mainly support people living with dementia. The service is divided up into three houses. Williamson is on the ground floor and caters for people living in the earlier stages of dementia. Also on the ground floor is a smaller house- Exmoor. This caters for people with complex needs due to their dementia needs. Upstairs there is one house for people living with dementia who were in a repetitive stage or advanced stage of their dementia. The provider has developed and implemented this care model based on the household model of care pioneered in the USA by LaVrene Norton, Action Pact and Steve Shields.

Heanton has a registered manager. 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.

Following the incident of one person swallowing a harmful substance, the provider had reviewed their policy and procedures to ensure this type of incident could not occur again. A harmful substance had been temporarily removed from a locked cupboard to a cupboard with a child lock. One person had accessed this cupboard and had put the substance in their mouth. They were found by a staff member. The provider has now put locks on all kitchen cupboards with the key being kept either in the nurse's station or out of eye sight of people living at the service.

The COSHH process and policy has been updated to inform staff about where harmful products should be stored and what protocols to follow when using these. Staff have been made aware of these changes via handover meetings, team meeting and electronic notification. All of the staff we spoke to were clear about the changes made to COSHH and what they should do if this type of incident did occur again.

Where staff were using wheelchairs to transport people around the home, risk assessments had been used to show whether they were at risk of falling out of their wheelchair. Where risks were identified, staff were instructed to use a lap belt. In the incident reported to us by the home, the person concerned had previously showed distress and anxiety when a lap belt was used. The service judged they were not at risk of falling out of their chair because they did not present with jerky movements and there was no history of slipping out of chairs. Following the incident of them slipping out of their chair, staff have been instructed to use a lap belt at all times for this individual.

Lessons learnt from these two incidents have been shared across the organisation. This included policy changes and changes to risk assessment processes.

There was sufficient staff available to meet the needs of people who lived at the service. People were kept safe because the provider had robust recruitment processes. Staff were only employed once checks and references had been obtained to ensure they were suitable to work with vulnerable people.

Staff understood how to keep people protected because they knew the types of abuse to watch out for and who and when to report their concerns.

People's care was well planned and risks had been assessed.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Risks had been clearly documented for staff to understand how best to keep people safe.

Staff knew about their responsibilities to safeguard people and to report
suspected abuse.

People were supported by enough staff to receive appropriate care. Robust recruitment procedures were followed to ensure appropriate staff were recruited to work with vulnerable people.

People received their medicines on time and in a safe way.

Is the service well-led?

Good

The service was well-led.

The registered manager and the provider of the service promoted strong values and a person centred culture.

Staff worked well together as a team and care was organised around the needs of people.

People, relatives and staff views were sought and taken into account in how the service was run.

The service had a variety of quality monitoring systems in place to monitor the quality of care and made changes and improvements in response to their findings.

Heanton Nursing 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.

The inspection was prompted in part by notifications of an incident following which a person using the service suffered harm after swallowing a harmful substance. We also received a notification about a person sustained a serious injury following a fall from their wheelchair. The first incident is also subject to a safeguarding process involving the commissioning teams and local safeguarding team. The police have also been involved in the investigation. The information shared with Care Quality Commission (CQC) about the incident indicated potential concerns about the management of risk of people having possible access to harmful substances. This inspection examined those risks.

CQC was made aware of a person swallowing a harmful substance by an initial phone call to us from the registered manager. The service were advised to send in a statutory notification, which they did. A notification is information about important events which the service is required to tell us about by law. Previously we had been made aware of the same person having swallowed shampoo. We did not ask for a notification because shampoo is not classed as a harmful substance and there were no ill-effects to the person. We were advised the person's risk assessment had been updated and their own toiletries had been removed. The person had a pressure mat to alert staff when they got out of bed as they were unable to use a call bell to ask for staff assistance.

We subsequently received a safeguarding alert from South West Ambulance Service Trust and the local hospital as the person had been admitted to hospital following a deterioration of their condition. This inspection was not an investigation of this incident. It was completed to ensure that any current risks to people's health, safety and welfare had been looked at by the provider and that where risks had been identified; measures were in place to mitigate those risks.

This inspection took place on 13 March 2018 and was unannounced. It was completed by one adult social care inspector.

During this inspection we
•□Completed a tour of all communal areas and checked the storage of harmful substances.
•□Checked what data sheets were held about each substance used in the home.
•□Checked policy and protocols about storage and use of harmful substances.
•□Spoke with eight staff about their understanding of any changes to protocol and storage of harmful substances following this incident.
•□Checked training records in respect of COSHH training.
•□Reviewed three records of care and support, including risk assessments, weights, and daily records showing what support had been given to people.
•□Checked risk assessment information for people at risk of falling out of their wheelchair.
•□Reviewed quality assurance processes about how the provider was assuring themselves people's care plans, risk assessments and daily records kept them safe, well and healthy.
•□Reviewed two recruitment files.
•□Checked audits relating to the storage, administration and recording of people's medicines.

Following the inspection we also spoke with the GP who visited the person.

Good

Our findings

When we last inspected the service in April 2017 we focussed on this one key question. This was because we had received some information of concern via the local safeguarding team. This information related to issues of infection control practices, people's care needs not being met, staff attitude, lack of respect and dignity and people being placed at risk from lack of hygiene and continence support. We did not find any evidence to support these areas of concern. We did however rate this area as Requires Improvement. This was because we observed some key times in specific areas where there may not have been enough staff to meet people's needs fully. We made a recommendation for the service to review the deployment of staff which they responded to.

At this inspection we saw there were sufficient staff available in each house to ensure people's safety. The provider had introduced housekeeper roles at the service. There were two housekeepers, one on each floor. Their role was to have oversight at mealtimes and throughout the day to ensure people have what they need. They also ensured people were fully supported to prevent the risk of choking when eating. They had also staggered staff breaks so staffing levels remained more consistent throughout the day.

Staff confirmed there were enough staff available throughout the day and evening to meet people's needs. Two staff mentioned they had occasional days when they were down on care staff numbers but this was due to staff ringing in sick as short notice. The registered manager said that where possible they asked staff to cover any gaps and if there were known gaps they used agency staff.

The Care Quality Commission was made aware of a person swallowing a harmful substance by an initial phone call to us from the registered manager. At that point they had not appeared to suffer any ill effects. They had been advised by the 111 service to monitor the person for symptoms. The service were advised to send in a statutory notification, which they did. We also advised they ensure the staff member concerned complete further COSHH training which the registered manager agreed they would action.

We looked at the measure in place to protect people from the risk of harm from harmful substances. Following this incident the service had made some changes to their policy and procedures. This included
•□Putting locks with keys on all communal kitchen cupboards where dishwasher tablets, washing up liquid and all-purpose cleaning fluid were held. These previously had a child lock in place.
•□Staff have been instructed not to bring harmful cleaning substances into the houses- until a solution is

made up in a bucket before hand.
• Non domestic staff no longer to have access these products.
• Domestic staff had clear instructions within the policy to not leave their cleaning trolley unattended. Since this incident the trolleys have also had a locked box added to keep cleaning materials in. The key was to be kept with the domestic staff member at all times.
• The policy clearly states that should someone ingest a harmful substance, staff are to call 999 immediately and ensure a copy of the COSHH data sheet goes with the person so there would be no confusion about what substance had been ingested.

We spoke with eight staff from different parts of the service and who worked in different houses. All were aware of the incident and what changes to the policy, procedures and their way of working had changed since this incident. All were able to detail the changes and said they had been informed via handover meetings, a team meeting and electronically via the caredocs system (Caredocs is the electronic system used by all staff for recording what daily tasks and activities they have completed with and for each person.) The changes made would mean people were protected from the risk of this type of incident occurring again.

We reviewed the training matrix and saw all but very new staff had completed training in COSHH. For those new staff plans were in place for them to complete this training. The training was an eLearning module with questions to answer at the end of the training. Staff was only able to gain their certificate if they passed a certain percentage of questions to show they had retained the information from the eLearning. Staff said the training was clear and gave them the information needed to ensure people's safety from harmful substances.

Prior to this incident, in October 2017, we were made aware via an email from the registered manager of a person having swallowed some shampoo. We did not ask for a statutory notification to be completed on this occasion. This was because the person did not suffer any ill effects and shampoo was not classed as a harmful substance. We were made aware that as a result of this incident the person's own toiletries were removed from their room. The person had a pressure mat to alert staff when they got out of bed. This was because they were unable to use a call bell to ask for staff assistance. The pressure mat would have alerted staff to the fact the person was up and they would check on them. The person was not in the habit of entering other people's rooms. When they were awake at night the person preferred to spend time in the communal lounge/diner areas watching TV. From these areas they would not have been able to access other people's bedrooms as doors leading to these were only accessible via a keypad. The service did not therefore feel it was necessary for other people's toiletries to be kept locked. Subsequent to this recent event the provider informed us they had risk assessed all other people living at the service. They did not find it necessary to lock any other person's toiletries away.

We reviewed three people's care plans and risk assessments and two of these in more detail. They were comprehensive and informed staff how best to support someone to keep them safe and well. The care plan was divided into clear sections which described people's needs and wishes. There were risk assessments in place for key areas such as risk of poor nutritional and fluid intake. Where such a risk had been identified, measures were in place to ensure the person's weight and food and fluid intake were closely monitored. Where staff had identified a decrease in weight, their care plan and risk assessment had been updated to reflect this. During the period of January and February 2018 a number of people had lost weight. This was due to them having suffered with chest infections and possible flu. People had been taking antiviral medicines as well as antibiotics for chest infections. There had been a high incident at this time of year of people in care homes and hospitals having suffered from such conditions. It was clear from the review of weights that some people weights had dipped but now they were over their illness were beginning to make improvements and their weight had increased.

In February 2018, the service notified us of an incident whereby a person had sustained a fracture following them sliding out of their wheel chair. They were not wearing a lap belt because using this type of equipment had caused the person distress in the past. Following this incident the service reviewed everyone using a wheelchair and risk assessed whether there was need for them to have a lap belt to keep them safe. This included he person who had sustained the injury. A protocol was drawn up for use across the provider's services which stated when and why lap belts must be considered. Following this, people were assessed and a list of those who had been assessed as needing a lap belt when being transported via a wheelchair was sent to all staff via caredocs mail. This included a note to all staff saying "Please ensure you all read and update yourselves with their care plans and risk assessments and this information is handed over to every shift daily." Staff confirmed they were aware of who needed to use a lap belt to keep them safe.

Staff understood the types of abuse that could occur and how to report concerns. Staff had received training in understanding abuse and the registered manager understood their responsibilities in working with the local safeguarding team when needed. The registered manager had a weekly face to face meeting with a member of the local safeguarding team to review any incidents and decide if further actions were needed. This might include asking for older people's mental health services to become involved and/or asked their GP to review their health and medicines needs. There was a high volume of reported incidents of people showing expressive behaviours and having altercations with each other. However, few serious incidents where people had been hurt as a result of these altercations. Care plans included instructions for staff about how to redirect people when they became agitated. This might include going out for a walk, moving to a different area and spending time talking with a staff member.

Recruitments practices were robust to ensure only staff who were suitable to work with vulnerable people were employed. New staff did not commence work at the service until all their references and checks were in place.

The service had developed personal emergency evacuation plans (PEEPs) for each person. They also had emergency plans in place if bad weather prevented staff being able to travel. For example the use of a four wheel drive vehicle which could be used to transport staff in snowy conditions. This had occurred in the last two months. The clinical director said staff had been exceptional in ensuring those who could get into work did so people's care, welfare and safety was not compromised.

At the last inspection we completed a full review of medicines practices so we did not review these again at this inspection. We did look at some audits relating to medicines records and recording of temperatures to ensure medicines were being stored at the correct temperature. We found they were.

The home's communal areas were clean and free from odour. The service employed cleaners who ensured all part of the home were kept clean and free from risk of infection. Staff had access to protective clothes and gloves and used these appropriately when needed. Staff confirmed they had received training in infection control and understood what additional measures may be needed should they have an infection control outbreak. The service had been awarded five stars, which is the highest rating from the Foods Standard Agency.

Good

Our findings

When we last inspected this key question at the comprehensive inspection in February 2017 we rated it as requires improvement. This was because at the time there was no registered manager in post. We also found that although systems had been set up to audit care and support, these had not picked on issues identified we had identified. For example, there had no medicine audits completed in the six months prior to the inspection. Failure to complete these had led to issues not being identified such as lack of recording of room and fridge temperatures and issues with records relating to medicine management. Similarly lack of auditing of the environment meant rooms were signed off as ready for use when not all safety aspects had been considered. We issued a requirement and asked the provider to send us an action plan showing how they intended to make the necessary improvements. At the focussed inspection in April 2017, we saw medicine audits had been implemented.

The service now had a registered manager. 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'. Staff said the registered manager was open and inclusive. They believed their ideas and suggestions as well as concerns were listen to and actioned. For example one staff member said "We suggested there was a need for more urine bottles in a particular house. The manager got these. I feel our opinion and suggestions are listened to."

Since the last comprehensive inspection there have been key changes and improvements to the quality monitoring processes. The provider's quality assurance team completed weekly and monthly audits in all clinical areas. This included ensuring people's weights were maintained; their food and fluid intake was monitored and recorded where needed. It also included a review of care plans and risk assessments as well as medicine audits. Some nurses were tasked with completing audits in house. We spoke with one nurse who had responsibility for the medicines audit. She explained the process and showed us records relating to these audits. There had been a significant improvement in the number of medicine errors in the last 12 months.

The provider quality team completed a monthly audit which included areas such as admissions, medicines, tissue viability, nutrition, the mealtime experience, quality of life and the Deprivation of Liberty Safeguards. These also included unannounced visits from the quality leadership team who visited at least once a month. Their observations of care and support were documented as part of the ongoing quality auditing process. This included good and not so good observations of care practices which they shared with the staff team as part of learning and improving. Where issues were identified, improvement plans were implemented. For

example, when weights showed a decrease, plans were implemented to more closely monitor those people who may have been at risk.

There was a strong commitment to continuous improvement through investment in staff learning and support. Over the last 12 months staff have completed all their health and safety training as well as specific training in the model of care the provider had implemented. One staff member said "I used to work in another nursing home, but this is by far the best one. The care here is not institutionalised, it is person centred. We have had lots of training to help us understand dementia and the different stages." Other staff confirmed they had been supported and encouraged to develop their skills via training, handover meetings and supervisions. The staff team had recently undertaken a day's training in all areas of the key question safe. Feedback from staff had been very positive. One said "All the information I got to help me improve my learning skills. Really helpful. Never been to a training event so interesting. Very happy to be to your company"

There was evidence of learning from incidents and accidents. This learning was shared across the organisation. For example the changes made to the policy and protocols in handling harmful substances. All incidents were discussed weekly with a member of the local safeguarding team to review if there were any patterns or trends. All accident reports were reviewed daily by the registered manager and any which needed action to ensure people's safety were followed up.

Surveys and meetings were used a formal way of obtaining people's views and feedback to help drive up improvement. Regular meetings were held with people's family's members. The minutes of the last meeting showed families were able to make suggestions and these had been actioned. For example the use of magnetic pictures to show which staff were on duty when they visited. Examples of how quality monitoring was being used were shared with families. The registered manager had informed the group that trends of accidents/incidents occur and that if patterns appear to be arising then a full review with the external quality assurance team is commenced.

At the reception desk there were feedback forms for anyone visiting to complete. Some of the comments from these have included the views of professionals who visited. One healthcare professional commented "Please can I take this opportunity to say thank you for the support you and your team give to (name of person). As you probably recall, there was initial concern that the staff group had very limited knowledge of learning disability and autism and the service was not orientated to support National Guidelines. This is now being dispelled by the compassion and enthusiasm of the team and their desire and commitment to ensure (name of person) feels welcomed, that they sees Heanton as their home, that their needs are met and that staff are sourcing information to help meet their needs. We have been impressed with the dignity and respect afforded to (name of person) …The engagement with our service has been very positive on our recent visits to Exmoor ." Other professionals have been less positive about their experience of Heanton. Recently two Devon County Council staff relayed concerns about lack of dignity for people and a strong smell of urine. We did not find any evidence to support this on this inspection visit.

The registered manager understood their role and responsibilities and had ensured CQC were kept informed of accident and incidents. Usually they liaised with the inspector via phone calls and emails to discuss actions taken and whether there was a need for a formal notification.

The provider had ensured their previous inspection report and rating was displayed in the main hallway of the home and on their website.