Abbey Healthcare (Kendal) Limited

Heron Hill Care Home

Inspection report

Valley Drive
Esthwaite Avenue
Kendal
Cumbria
LA9 7SE

Date of inspection visit:
05 April 2017
12 April 2017
27 April 2017

Date of publication:
11 August 2017

Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
Is the service caring?	**Good**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This inspection took place on 05, 12 and 27 April 2017. Visits to the service on 05 and 27 April 2017 were unannounced; we told the provider that we would return to the service on the 12 April 2017. We last inspected the service on 05 and 06 December 2017 when the service was judged to be in breach of seven regulations.

During this inspection we reviewed the action taken by the provider to meet the requirements of the regulations, these included; safe care and treatment, including medicines management. Person-centred care. Need for consent. Safeguarding service users from abuse and improper treatment. Premises and equipment in relation to infection control and environment maintenance. Good governance and staffing.

At this inspection we found the provider was still in breach of the regulatory requirements for safe care and treatment, including the proper and safe management of medicines. Person-centred care. Need for consent. Safeguarding service users from abuse and improper treatment. Good governance and staffing.

We found that the provider had made some improvements, which are included in the main body of this report. The provider was no longer in breach of Regulation 15 in relation to premises and equipment.

The overall rating for this service is 'Inadequate' and the service remains in 'special measures'. The purpose of special measures is to:
Ensure that providers found to be providing inadequate care significantly improve. Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made. Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will be kept under review and if needed could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

Heron Hill Care Home provides accommodation and nursing care for up to 86 people. The home is over three floors and has three separate units. Each unit has a separate dining area and communal lounge. On the ground floor Nightingale Unit provides general nursing care; on the first floor Cavell Unit provides nursing care for people living with dementia and on the second floor McKenzie Unit provides care for males

living with dementia.
There is a hair dressing room in the service. All bedrooms are of single occupancy and have ensuite facilities. The service provides support to adults who have a physical disability, mental health needs, behavioural support needs, dementia and complex nursing needs. One unit is a 20 bedded all male unit, for those who may present more challenging behaviours that need specialist input. At the time of the inspection there were 76 people living at the service.

There was a newly appointed manager in place who had applied to become a registered manager. The manager had been promoted from deputy manager and was being supported by the nominated individual during their induction period. The manager had submitted their application to CQC to become 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.

A Nominated Individual is a person who has registered with the Care Quality Commission and must be employed as a director, manager or secretary of the organisation with responsibility for supervising the management of the regulated activity.

The manager and nominated individual were available throughout the inspection and received verbal and written feedback.

People told us they felt safe at the service and with the staff who supported them. The service had procedures in place for dealing with allegations of abuse. Staff were able to describe to us what constituted abuse and the action they would take to escalate concerns.

Staff members spoken with said they would not hesitate to report any concerns they had about care practices.

On the third day of the inspection we found examples of people being deprived of their liberty. For example, one person was being assisted with personal care on a daily basis, due to their resistance to care support. Staff told us they had to use low level restraint, also known as safe holds during personal care interventions. The restrictive practice had not been formally risk assessed or care planned and a DoLS application had not been submitted. This meant that the person was being unlawfully restrained. We looked at a DoLS urgent authorisation for the same person in relation to a secure environment. The authorisation had expired in 2015 and was still held on the person's care records. This meant that the person was at risk of being unlawfully restricted.

After the inspection the manager provided us with information following a full audit of restrictive practices at the service, a further 26 DoLS applications had been submitted, due to people living within a secure environment and or resisting personal care interventions.

We found the provider to be in breach of regulation 13 of the Health and Social Care Act 2014, safe guarding service users from abuse and improper treatment.

We received feedback from the local safeguarding team within Cumbria County Council who told us that the provider had continued to raise safeguarding referrals and had been responsive to actions set by the

safeguarding team to protect service users involved.

People's needs were not always risk assessed against avoidable harm and injury. Care records showed general risk assessments had been completed. However, person centred risk assessments had not always been undertaken; for example, when people were at risk of choking or aspirating. This placed people at significant risk of harm.

One person's care records showed that they had not been adequately risk assessed following two falls. Their care plan for falling had not been updated to show how they would be supported and monitored to prevent further incidents, which could cause harm and personal injury. Another person's care records stated that they required a soft diet; when we visited the person in their bedroom we found that they had been given chicken, hard boiled potatoes and carrots. This meant that the person was at risk of choking. We informed the manager immediately and action was taken to provide the person with the correct meal type.

This meant that the provider continued to be in breach of Regulation 12 of the Health and Social Care Act 2014, safe care and treatment in relation to personal risk assessment.

The care records we looked at showed that pre-admission and admission risk assessments and care planning had improved since the last inspection.
The environment was clean and well maintained. We found that infection control systems had improved and were being monitored by the manager. This was an improvement since the last inspection.

The manager showed us plans for replacement of corridor flooring on the McKenzie Unit. After the inspection we were sent a risk assessment from the provider in relation to planned arrangements to ensure the safety of people who lived at the service during the replacement of flooring. The manager updated us on 11 May 2017 and confirmed that the work was nearly completed and some service users had been moved during the day to Cavell Unit to provide a safe environment.

On the first day of inspection we looked at bedrail safety. We found that all bedrail bumpers were in place with the exception of one. Action was taken immediately by the manager. On the third day of our inspection we checked all bedrails used at the service; we found that all bedrails had bumpers. This was an improvement since the last inspection. Bedrail bumpers prevent injury and entrapment for people that require bedrails whilst in bed.

On the first day of the inspection we informed the manager that a sluice had been left unlocked on the Nightingale Unit. Action was taken to lock the sluice. On the third day of the inspection we found that the sluice was again left unlocked. This placed people at risk of personal injury. Sluice areas are prohibited for people that live at the service, due to risk of exposure to chemicals and clinical waste.

On the first day of the inspection we looked at the provider's fire risk assessment undertaken by an independent company on 22 February 2017. The fire risk assessment identified four areas that required action to be taken within 1-5 days. High risk areas had not been addressed, these included removal of combustible materials from the electrical room and plant room. This placed people at immediate risk of harm. We informed the nominated individual who took action and areas of hazard were cleared immediately.

This meant that the provider was in breach of Regulation 12 of the Health and Social Care Act 2014, safe care and treatment in relation to premises safety.

We found that staff recruitment was safe and staff were supported throughout their induction process. We received feedback from staff and relatives on the first day of the inspection regarding staffing levels on McKenzie Unit. People told us that staffing was not sufficient to meet the needs of those who lived on the unit. We discussed this with the nominated individual and staffing was increased. We received confirmation after the first day of the inspection from the manager, who told us that the increased staffing levels would be maintained for the foreseeable future.

We found that medicines management systems were not robust and this meant that people were at risk of not receiving their medicines as prescribed. The provider has been in breach of Regulation 12 of the Health and Social Care Act 2014, safe care and treatment in relation to the proper and safe management of medicines since July 2015, the previous two inspections.

We found that issues highlighted at the last inspection in relation to medicines management, such as clinic room temperatures, fridge temperatures, completion of medication administration records had been addressed and improved. However, some of the concerns highlighted at the last inspection continued to require improvement, such as the management of 'when required' medicines.

We looked at staff support systems. Supervision and appraisal records were not available for all staff and the supervisions we looked at were not in relation to the staff's personal development and employment; they were in relation to training subjects. We have made a recommendation about this. Staff told us that they felt supported and were pleased about the recent appointment of the new manager.

Records and certificates of training showed that a wide range of training had been provided for all staff. The manager updated us on 11 May 2017 in relation to staff training. Electronic learning statistics showed that 68% of staff had completed mandatory training subjects, staff had recently started annual training updates so statistics had reduced. Practical training for subjects such as moving and handling and fire awareness had been undertaken and planned for all staff at the service.

We found staff knowledge of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) had improved. The service had procedures in place for assessing a person's mental capacity in line with the MCA 2005, however records showed that processes were not always robust.

The provider continued to be in breach of Regulation 11 of the Health and Social Care Act 2014, need for consent.

We received mixed feedback from people who lived at the service and relatives with regard to the quality of food provided at the service. People were assessed on an individual basis and nutrition care planning showed people's needs and preferences. However, people's needs and preferences were not always adhered to. We found two people had lost a significant amount of weight and had not been referred to dietetic services in a timely manner.

The provider was found to be in breach of Regulation 14 of the Health and Social Care Act 2014, meeting nutritional and hydration needs.

We undertook a joint inspection with Environment Health, who had returned to the service to review concerns found on their initial day of inspection 21 March 2017. Environmental Health provided us with feedback which included risk's associated with food operations. They found out of date cooked meat in the fridge and staff confirmed that the meat would have been served later that day. The manager told us that he had been undertaking twice daily checks of the kitchen and had found out of date meat on a second

occasion and this had been disposed of. The provider told us that they will continue to undertake twice daily kitchen audits. Environmental Health will report on their findings.

We observed care practices across all units. Staff were caring and response to people's requests. People who lived at the service and their relatives told us that staff were kind and cared about their wellbeing.

We observed improvement's across both dementia care units in relation to support for people who experience distressed reactions. McKenzie Unit caters for people with complex mental health needs and we observed staff assist people with a skilled approach. We received feedback from external professionals in relation to the reduction of distressed reactions for people who lived on the McKenzie Unit.

We saw within people's care plans that referrals were made to other professionals in order to promote people's health and wellbeing. Examples included, referrals to social workers, pressure care specialists, physiotherapists and GPs. However, dietician advice was not always sought in a timely manner. The service engaged with the NHS Care Home Effective Support Service (CHESS) and we received positive feedback in relation to improved communications with the team and actioning of care plans.

Information about advocacy and other services was displayed around the service and staff were aware of the need for promoting advocacy and involving people's next of kin when appropriate.

We looked at complaints management and found that the manager dealt with complaints in a timely manner and maintained records. The manager had advertised a weekly 'managers surgery' for service users and relatives to access, the notice also stated that the manager was available throughout the week should people who live at the service or their relatives need to make contact.

We found that people's care plans had been written in a person centred way, however the service did not always ensure that care plans were updated when a person's needs changed, for example after they had fallen. We also found that people's recorded preferences were not always provided. For example, one person told us that staff did not call them by their preferred name. Another person's care plan stated that they did not like tea or coffee, we found that since their admission only tea and coffee had been offered. This meant that people did not always receive person centred care.

We looked at daily care records on the Nightingale Unit. We found significant gaps in recording. This meant that the service did not always clearly demonstrate when a person had been supported with pressure care, nutrition and hydration, bowel care and personal hygiene.

We found that the service had a quality auditing system in place. The manager carried out regular audits in areas such as, accidents and incidents, staff records, medication, cleaning, maintenance and care planning. We saw audits had been completed on a regular basis. However medication, care planning and accident/incident audits had not highlighted the concerns we found during the inspection.

During the inspection the manager increased auditing systems by doing a full check of areas such as kitchen performance, Do Not Attempt Cardiopulmonary Resuscitation document's (DNA CPR), mental capacity assessment and nutritional needs. This was following our feedback.

The provider continued to be in breach of Regulation 17 of the Health and Social Care Act 2014, good governance.

We found the provider was in breach of multiple regulations of the Health and Social Care Act 2008

(Regulated Activities) Regulations 2014. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

You can see what other action we have told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

We found that people were not always effectively safeguarded against abuse in relation to Deprivation of Liberty Safeguards. However, staff knowledge was efficient in regards to what abuse means and the safeguarding referral processes.

People were not always assessed against the risk of choking, aspiration and falling.

Medicines management continued to require improvement to ensure that safe systems were embedded.

Staff were suitably recruited.

The home was clean and infection control systems had improved. However, we found that fire risks had not been addressed.

Is the service effective?

Inadequate

The service was not consistently effective.

Staff had access to on-going training to meet the individual needs of the people they supported.

The provider had not undertaken individual supervision and appraisal processes for staff employed at the service.

The service had policies in place in relation to the Mental Capacity Act 2005 (MCA) and depriving people's liberty, where this was in their best interests. Improvements were required to ensure that the processes were followed.

People who lived at the service were not always risk assessed in relation to nutrition and hydration. Records showed gaps in the monitoring of people's diet and fluid intake.
We found examples of people being at significant risk of choking and weight loss that had not been well managed.

People had access to healthcare services. However, we found

that dietician referrals were not always undertaken in a timely manner.

Is the service caring?

Good

The service was caring.

The service had a system in place for care plan review and service user involvement in the care planning process; however, we found that these were not always completed.

People were supported by staff in a kind and caring way. We observed staff support people who lived with dementia in a therapeutic way.

People had access to advocacy services, should they wish to do so. An advocate is an independent person, who will act on behalf of those needing support to make decisions.

The service provided a good standard of end of life care.

Is the service responsive?

Requires Improvement

The service was not always responsive.

We found some gaps in person centred care planning and risk assessment.

People did not always receive person centred care.

People were not always provided with pressure relief in a timely manner This placed them at risk of developing pressure sores.

Pre-admission assessments were undertaken before a person was admitted to the service and care plans on admission were completed with a good standard of person centred detail.

We found that the provision of activities required improvement. People we spoke with told us they knew how to raise issues or make complaints. Complaints were recorded and the manager's response letter was held on file.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

A wide range of updated policies and procedures were in place at the service, which provided the staff team with current

legislation and good practice guidelines.

Quality assurance audits were in place, however these did not always highlight shortfalls found at this inspection.

Staff spoken with felt well supported by the management team and were very complimentary about the way in which the service was being run. The new manager was being supported by the nominated individual.

Heron Hill 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 unannounced inspection took place on 05 12 and 27 April 2017 and was carried out by four adult social care inspectors, a pharmacy inspector and two experts-by-experience.

An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert by experience's had personal experience of caring for a relative who lived with dementia and older people.

Before the inspection visit we reviewed the information we held about the service, which included information such as notifications informing us about significant events and safeguarding concerns, any contact from other professionals and contact from people using the service and/or family or carers.

During the inspection we spoke with a range of people about the service; this included 17 people who lived at the service, 14 relatives and 15 members of staff. We contacted professionals who visited the service and local commissioning groups responsible for external monitoring of the service.

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 'pathway tracked' the care of ten people who lived at the home. This enabled us to determine if people received the care and support they needed and if any risks to people's health and wellbeing were being appropriately managed.

We spent time looking at other records, which included 13 people's medicine records, three staff files, training records and records relating to the management of the home, which included audits for the service.

Inadequate

Is the service safe?

Our findings

We spoke with people who lived at the service and asked them if they felt safe. People told us that they were happy at Heron Hill Care Home and felt safe. We spoke with people's representatives on both units and they told us, "I feel [name] is safe from abuse and harm". And, "Staff do the best that they can and [name] is well cared for".

The service had procedures in place for dealing with allegations of abuse. Staff were able to describe to us what constituted abuse and the action they would take to escalate concerns.

Staff members spoken with said they would not hesitate to report any concerns they had about care practices.

We received feedback from the local safeguarding team within Cumbria County Council who told us that the provider had continued to raise safeguarding referrals and had been responsive to actions set by the safeguarding team to protect service users involved.

At the last inspection we found the provider to be in breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, the provider had not done all that was reasonably practical to assess and mitigate the risks to people living at the service. At this inspection we found that the provider continued to be in breach with this regulation.

People's needs were not always risk assessed against avoidable harm and injury. Care records showed general risk assessments were completed, however person centred risk assessment had not always been undertaken. For example, when a person was at risk of choking or aspiration. This placed people at significant risk of harm.

One person's care records showed that they had not been adequately risk assessed following two falls. Their care plan for falling had not been updated to show how they would be supported and monitored to prevent further incidents which could cause harm and personal injury. Another person's care records stated that they required a soft diet; when we visited the person in their bedroom we found that they had been given chicken, hard boiled potatoes and carrots. This meant that the person was at risk of choking. We informed the manager immediately and action was taken to provide the person with the correct meal type.

On the first day of the inspection we observed people on Nightingale and Cavell Unit to be left in wheelchairs for excessive periods of time, from breakfast until late afternoon, we prompted staff to assist people into comfortable seating. This meant that people were at risk of developing pressure related wounds.

The above shortfalls meant that the provider continued to be in breach of Regulation 12 of the Health and Social Care Act 2014, safe care and treatment. In relation to personal risk.

After the inspection the provider updated us with training information. All staff had been scheduled to attend training on understanding texturised diets. The provider also confirmed in writing that all service users had been reassessed for nutrition needs and risk assessments had been implemented as required.

The care records we looked at showed that pre-admission and admission risk assessment and care planning had improved since the last inspection. We looked at the most recent admission to the service on the second day of the inspection and found that their needs had been assessed. However, their medicines on admission had not been fully checked against their previous hospital prescription; this meant that the person was at risk of not receiving their medicines as prescribed. On the third day of the inspection we looked at another person who had been admitted and their medicines had been accurately checked in.

At the last inspection we found the provider to be in breach of regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, the provider had not done all that was reasonable practical to ensure that the premises were safe and facilitated the prevention of infection control. At this inspection we found that improvements had been made in this area and the provider was now compliant with regulation 15. The environment was clean and well maintained. We found that infection control systems had improved and were being monitored by the manager. This was an improvement since the last inspection.

We observed staff carry out safe infection control practices and staff told us that they had access to protective clothing.

The manager showed us plans for replacement of corridor flooring on the McKenzie Unit. After the inspection we received risk assessments in relation to planned arrangements to ensure the safety of people who lived at the service during the replacement of flooring. The manager updated us on 11 May 2017 and confirmed that the work was nearly completed and some service users had been moved during the day to Cavell Unit to provide a safe environment.

On the first day of inspection we looked at bedrail safety. We found that all bedrail bumpers were in place with the exception of one. Action was taken immediately by the manager. On the third day of our inspection we checked all bedrails used at the service and found that all bedrails had the required protective bumpers in place. This was an improvement since the last inspection. Bedrail bumpers prevent injury and entrapment for people that require bedrails whilst in bed.

On the first day of the inspection we informed the manager that a sluice room had been left unlocked on the Nightingale Unit. Immediate action was taken to lock the sluice. On the third day of the inspection we found that the same sluice room was again unlocked. This placed people at risk of personal injury, sluice areas are prohibited for people that live at the service due to risk of exposure to chemicals and clinical waste.

On the first day of the inspection we looked at the provider's fire risk assessment undertaken by an independent company on 22 February 2017. The fire risk assessment identified four areas that required action to be taken within 1-5 days. High risk areas had not been addressed, these included removal of combustible materials from the electrical room and plant room. This placed people at immediate risk of harm. We informed the nominated individual who took action and areas of hazard were cleared immediately.

This meant that the provider was in breach of Regulation 12 of the Health and Social Care Act 2014, safe care and treatment in relation to premises safety.

At the last inspection we found the provider to be in breach of regulation 12 of the Health and Social Care

Act 2008 (Regulated Activities) Regulations 2014, in relation to safe and proper management of medicines. Although some improvements had been made we found the provider to still be in breach of this regulation.

On the second day of the inspection we looked at medicines management. We found that medicine records were not always accurately completed. Staff had not correctly reconciled one person's medicines when they were admitted to the Home in line with their medicine policy. The person had come into the home the day before our visit and brought in their medicines and a copy of their prescription. However, we saw that one medicine on the medication list had not been brought in to the service and therefore could not be given. Another medicine was listed with a handwritten alteration of dose. The Resident's GP had not been contacted to verify the dose to be given or that the medication brought in, was in accordance with their current regime.

For the same person the handwritten Medication Administration Record (MAR) had been written by one nurse and checked by a second nurse for accuracy, however it was not accurately completed. Two medicines which were administered from the blister pack (pharmacy supplied medicine packaging) were not listed on the MAR, this had not been picked up by the second check.

When we checked a sample of other medicines alongside the records, we found that inhalers for two people, liquid medicines for two people and one eye ointment did not match up. This meant we could not be sure if people were having these medicines administered correctly.

Some people were prescribed topical medicines to be applied to the skin, for example creams and ointments. Topical MARs and body maps were mostly in place to guide care staff when and how to apply these creams; however people did not always receive them as they had been prescribed. For example, one person should have had a cream applied thinly twice daily to psoriasis. Their topical MARs indicated this had been applied just once daily. In addition, we found another cream prescribed for use as a soap substitute and frequently at least four times daily where the topical MAR records showed that this had only been applied twice daily.

Some people were prescribed medicines to be given 'when required'. We found protocols were not always in place to guide staff on when and how to safely administer these medicines. For one person, the guidance for prescribed pain relief medication stated that the pain score should be noted on the reverse of the MAR, however not all administrations had been documented on the reverse and none had the pain score recorded. This information would help to ensure that people were given their medicines in a safe, consistent and appropriate way.

Some people were being given medicines covertly (disguised in food or drink), however we found appropriate assessments and records were not completed in line with the Home's policy. For example, one person had two new medicines introduced recently, we found that the pharmacist had not been consulted about the method of administration of the medicines and there was no information on the MAR to say how they would be administered. For another person a list of medicines administered covertly was available but this had not been signed or dated by the pharmacist, so it was not clear whether they had been consulted.

The above failings contributed to a continued breach of Regulation 12 Safe care and treatment of the Health and Social Care Act (Regulated Activities) Regulations 2014 in relation to the proper and safe use of medicines.

We found that issues highlighted at the last inspection in relation to medicines management such as clinic room temperatures, fridge temperatures, and completion of medication administration records had been

addressed and showed improvement.

Medicines were stored safely and securely and access to them was restricted to authorised staff. The home had appropriate arrangements in place for the management of controlled drugs (medicines that require special checks and storage arrangements because of their potential for misuse).

All of the records we reviewed contained a photograph of the person concerned and included their allergy status. This reduces the risk of medicines being given to the wrong person, or to someone with an allergy. We looked at the current medicines administration record for one person prescribed a medicine that required regular blood tests. Arrangements were in place for the safe administration of this medicine.

For a medicine that staff administered as a patch, a system was in place for recording the site of application and this was fully completed for one person whose records we looked at. This is necessary because the application site needs to be rotated to prevent side effects.

We looked at how medicines were monitored and checked by management to make sure they were being handled properly and that systems were safe. The manager completed regular audits that had identified some but not all of the issues found during our visit.

We found that staff recruitment was safe and staff were supported throughout their induction process. We received mixed feedback from relatives on the first day of the inspection regarding staffing levels on McKenzie Unit. Relatives told us; "There are not enough staff to take the residents out to the garden, they have lost one staff member recently and it makes a difference". "If there were more staff there would be more stimulation, the lack of stimulation is down to staffing". "The staff sometimes seem a bit stressed, maybe they could do with more staff". "I would say that 90% of time there is enough staff". And, "Yes I think so there's enough staff, most of time, except when they are really busy".

Staff from the McKenzie Unit told us; "We are short staffed on the unit". And "We can just about manage with the amount of staff we have, but it doesn't leave much time for us to sit and talk to people, or take people off the unit for fresh air".

We looked at accidents and incidents on McKenzie Unit and saw that there had been a significant reduction.

We discussed this with the nominated individual on the first day of the inspection and staffing levels were increased. We received confirmation after the first day of the inspection from the manager who told us that the increased staffing level would be maintained for the foreseeable future.
Staffing on the other units appeared sufficient to meet the needs of people who lived at the service. The manager showed us a dependency assessment tool and had recently developed a new document named 'bed status' that included resident details, medical status, mental capacity information and dependency requirements. The document was received well by the care and nursing staff and was effective in supporting agency staff to have an over view of people's needs.

Inadequate

Is the service effective?

Our findings

We asked people if they were supported by skilled and experienced staff. People who lived at the service told us; "I am well looked after". "Staff are very good". And "Staff on the whole are very good and approachable". People's representatives told us; "The nurses are brilliant keep you informed". And "Staff are fine, I am confident to approach the nurse if I had any worries".

At the last inspection we found the provider to be in breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, the provider had not made sure that all people using the service or those acting on their behalf had given lawful consent.

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 and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA.

At this inspection we found staff knowledge of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) had improved. The service had procedures in place for assessing a person's mental capacity in line with the MCA 2005, however records showed that processes were not always robust.

The service had implemented mental capacity act assessments for various decisions in relation to care and treatment. The assessments were basic and did not always outline how the person's mental capacity had been assessed. For example, the time of day the assessment was undertaken, questions asked and responses from the individual being assessed.

We looked at Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) documents for six people that lived at the service, we found that there were concerns around the DNACPR' documentation for treatment decisions and consent to DNACPRs and this placed people at significant risk of receiving treatment that was not in line with their needs or wishes. The provider acted upon our concerns and contacted involved external professionals responsible for review of the documents. On the third day of the inspection we found that DNA CPR documents that had been reviewed since the first day of inspection were still not accurately completed. The provider had taken steps to improve however external professional's completing the documents had failed to ensure that the DNA CPR's were valid and fit for purpose. This meant that people who lived at Heron Hill Care Home with DNACPR decision remained at risk of receiving treatment that was not in line with their needs or preferences.

We have communicated our concerns to involved external health care professionals.

The provider continued to be in breach of Regulation 11 of the Health and Social Care Act 2014, need for consent.

On the third day of the inspection we found examples of people being deprived of their liberty. For example one person was being assisted with personal care on a daily basis, due to their resistance to personal care support. Staff told us they had to use low level restraint also known as safe holds, during personal care interventions. The restrictive practice had not been formally risk assessed or care planned and a Deprivation of Liberty Safeguards (DoLS) application had not been submitted. This meant that the person was being unlawfully restrained. We looked at a DoLS urgent authorisation for the same person in relation to a secure environment. The authorisation had expired in 2015 and was still held on the person's care records. This meant that the person was at risk of being unlawfully restricted. Following our inspection the manager provided us with information following a full audit of restrictive practices at the service, a further 26 DoLS applications had been submitted due to people living within a secure environment.

The above mentioned unlawful restrictions of peoples liberty meant that we found the provider to be in breach of regulation 13 of the Health and Social Care Act 2014, safe guarding service users from abuse and improper treatment.

We received mixed feedback from people who lived at the service with regard to the quality of food provided at the service; "I don't like the meals there is a lot of pasta, we have soup and sandwiches every lunch time". "There are lots of curries, chillies and casseroles. There are lots of people in bed at tea time so the food is quite often cold after serving everyone". "The food is alright". "We get plenty of choice". "The food is alright, we get enough choice". People's representatives told us; "I would say [name] gets good food" and "I come at lunch time three to four times a week I help [name] with their lunch. The food is very good".

On the first day of the inspection we were joined by an Environmental Health Officer. Environmental Health provided us with feedback following their initial day of inspection on 21 March 2017, which included risk's associated with food operations. At that inspection they had found out of date cooked meat in the fridge and staff confirmed that the meat would have been served later that day. The manager told us that he had been undertaking twice daily checks of the kitchen following the environmental health inspection and had found out of date meat on a second occasion and that this had been appropriately disposed of. The provider told us that they would continue to undertake twice daily kitchen audits. Environmental Health will report separately on their findings.

People were assessed on an individual basis and nutrition care planning showed people's needs and preferences in most cases. However, people's needs and preferences were not always adhered to. We looked at the care records for one person who had lost 8kg since their admission to the service in January 2017. They were not referred to the dietician until April 2017 following the identification of 8kg weight loss. Before the person came to the service they were prescribed food supplements to help with weight gain, these were no longer on their prescription sheet and there was no reason recorded as to why these were not being provided. The same person was assessed by the Speech and Language Team (SALT) whilst in hospital and a soft textured diet had been advised. On the first day of the inspection we observed the person being served toast at breakfast time. We discussed this with the unit manager who agreed that this was not safe for the person to eat and placed them at risk of choking. On the third day of the inspection we visited the same person again in their bedroom. The evening meal served for them was chicken in breadcrumbs, hard boiled new potatoes and carrot batons. We immediately informed the manager who took action to inform staff and provide a suitable diet type. This placed the person at significant risk of choking.

On the first day of the inspection we looked at care records for a second person who had lost 10kg in three months. A person centred weight loss care plan had not been written and referral to dietetic services was not made until the 10kg weight loss was recorded. This meant that preventative measures had not been taken to reduce the risk of further weight loss. On the third day of the inspection we looked the person's nutritional care plan to check if a weight loss care plan had been written. Their nutrition care plan written on 11 April 2017 stated that the service user should be offered small amounts of food between meals and a normal diet was required. Food intake records from 12 April 2017 to 17 April 2017 showed that no snacks had been offered between meals. Food intake records on 15 April 2017 detailed "12.00hrs; [name] wouldn't wake up, very sleepy told not to feed, nurse instructions' and 17.00hrs; 'Nurse instruction, first give fluid prone to choking'. Following this information a risk assessment and associated care plan was not formulated in relation to their choking risk. This exposed the person to the risk of malnutrition, choking and aspiration.

The provider was found to be in breach of Regulation 14 of the Health and Social Care Act 2014, meeting nutritional and hydration needs.

At the last inspection we found the provider to be in breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, the provider had not made sure that all staff had received the training relevant to their roles. At this inspection we found that the provider at met the requirements of this regulation and was no longer in breach.

At this inspection we looked at staff support systems. Supervision and appraisal records were not available for all staff and the supervisions we looked at were not in relation to the staff's personal development, they were in relation to training subjects. Staff told us that they felt supported and were pleased about the recent appointment of the manager.

We recommend that the provider improves the recording of one to one support meetings for staff employed at the service.

Records and certificates of training showed that a wide range of training had been provided for all staff. The manager updated us on 11 May 2017 in relation to staff training, electronic learning statistics showed that 68% of staff had completed mandatory training subject, staff had started annual training updates so statistics had recently reduced.

Practical training for subjects such as, moving and handling, distressed reactions and fire awareness had been undertaken or planned for all staff at the service.

Good

Is the service caring?

Our findings

We received positive feedback about the care provided from people who lived at the service, their representatives and visitors. People told us; "It is very good here, the staff are fine". "Friends and family can visit whenever they want to". "The staff are caring". "The staff are very good". "I can visit [name] whenever I want". "The staff are brilliant here". "They treat [name] with dignity and respect, they close [names] door, pull curtain round when dealing with [name]". And "I am very happy with the way [name] is cared for".
We observed care practices across all units. Staff were caring and responsive to people's requests.

We observed improvement's across both dementia care units in relation to support for people who experience distressed reactions. McKenzie Unit caters for people with complex mental health needs and we observed staff assist people with skilled interventions. We received feedback from external professionals in relation to the reduction of distressed reactions for people living on the McKenzie Unit.

We observed positive interactions between staff and people who lived at the service. Staff were attentive and were able to acknowledge people's non-verbal communications. We saw staff talk to people in a person centred way and encouraged them to participate in the activities on the unit.

On the third day of the inspection we observed staff on Nightingale Unit engage with service users during musical entertainment. A care assistant sat with a service user holding their hand and we could see that a trusting relationship had been formed between the service user and staff member.
We observed staff knock on people's doors before entering and when people asked to be assisted to the bathroom staff promoted their dignity.
We saw within people's care plans that referrals were made to other professionals in order to promote people's health and wellbeing. Examples included referrals to social workers, pressure care specialists, physiotherapists and GPs. However, dietician advice was not always sought in a timely manner. The service engaged with the NHS Care Home Effective Support Service (CHESS) and we received positive feedback in relation to improved communication with the team and actioning of care plans.

Information about advocacy and other services was displayed around the service and staff were aware of the need for promoting advocacy and involving people's next of kin when appropriate.

The manager showed us a schedule for resident and relative meetings for 2017. Since the manager has taken up post one resident /relative meetings had been held. Minutes were recorded and shared after the meeting.
We did not find evidence of care plan agreements within the care records we looked at. Service user involvement throughout the care planning process is important and promotes person-centred care. The manager told us that care plan reviews were to be scheduled and key workers were being allocated at the time of our inspection.

Requires Improvement

Is the service responsive?

Our findings

At the last inspection we found the provider to be in breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, the provider had not ensured that people were assessed and that their person-centred needs were recorded. At this inspection we found that provider had made improvements around the detail within people's care plans. However, care plans were not always followed.

We pathway tracked the care of ten people who lived at the service. This enabled us to determine if people received the care and support they needed and if any risks to people's health and wellbeing were being appropriately managed.

We found that people's care plans had been written in a person centred way, however the service did not always ensure that care plans were updated when a person's needs changed, for example after they had fallen. We also found that people's recorded preferences were not always provided. For example, one person told us that staff did not call them by their preferred name. Another person's care plan stated that they did not like tea or coffee, we found that since their admission only tea and coffee had been offered. This meant that people did not always receive person centred care.

We looked at daily care records on Nightingale Unit. We found significant gaps in recording. This meant that the service did not always clearly demonstrate when a person had been supported with pressure care, nutrition and hydration, bowel care and personal hygiene.

We looked at a hospital passport for a person who lived on Nightingale Unit; the hospital passport is a document that is kept on the persons care file completed and ready to be used in the event of an emergency or planned hospital admission. The hospital passport detailed how the person should be cared for, but did not include that the person was at risk of choking and aspiration, as detailed in their nutritional care plan. This meant that during transition between services the person was at risk of receiving unsafe care and treatment that was also not person-centred.

The above short falls constituted to a continued breach of Regulation 9 of the Health and Social Care Act 2014, person-centred care.

We received feedback from people who lived at the service and their representatives about recreational activities; "[name] likes his own company at times so staff let [name] have time alone so [name] can read his truck magazines [name] is not one for group work". "[name] is well looked, [he] sits in the lounge with the other residents it's a community even though some residents don't speak and are asleep they have each other to look at, it's better than sitting in their room". "The staff could do a little more to stimulate people but on Mothering Sunday [name] was brought down stairs and had a sing song and listened to music, [name] likes music and was singing all day after that". "There are no activities". "We do activities". "We don't get taken out". And "I don't think we do many activities".

On the first day of the inspection we observed activities taking place on Cavell Unit. Staff engaged with

people who lived on the unit and people looked to be enjoying the music by singing along and smiling. On the third day of the inspection we observed people from all units go down to Nightingale Unit and watch an entertainer who performed music from past times.

The nominated individual told us that activities at the service were not person centred and needed improvement. After the inspection the manager sent us an action plan which detailed arrangements to improve activities. A new activities team leader had been appointed and they were contracted to work alternate weekends. There were 5 activity staff employed at the service and a new activity schedule was being devised for each unit. The manager also informed us that each service user would have an individualised activity care plan incorporating their hobbies, past times and interests.

There was evidence available to demonstrate that an assessment of a person's needs had been conducted before a placement at the service had been arranged. This helped to ensure that the staff team were confident that they were able to provide the care and support required by each individual who came to live at the service.

We looked at complaints management and found that the manager dealt with complaints in a timely manner and maintained records. The manager had advertised a weekly 'managers surgery' for service users and relatives to access, the notice also stated that the manager is available throughout the week should people who live at the service or their relatives need to make contact.

We noted that profile beds and specialised mattresses and specialist seating were provided for all those who required.

There was a fully equipped hair salon available on the ground floor. This helped to provide people with maintaining their independence.

We saw that people had televisions in their bedrooms and bedrooms had been personalised.

Requires Improvement

Is the service well-led?

Our findings

People who lived at the service and their representatives provided us with feedback about how the service was led; "The new manager is good". "I am concerned that the manager is not a nurse and does not have a clinical back ground". "I have never had reason to complain". "The manager is visible around the home and involved".

At the last inspection the provider was found to be in breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to quality management systems, we found that systems had not been effectively implemented to assess, monitor and improve the quality and safety of the services provided. At this inspection we found that quality monitoring systems had improved, however were not robust and did not identify all of the failings found at this inspection.

We found that the service had a quality auditing system in place. The manager carried out regular audits in areas such as, accidents and incidents, staff records, medication, cleaning, maintenance and care planning. We saw audits had been completed on a regular basis. However, medication, care planning and accident/incident audits had not highlighted the concerns we found during the inspection. Kitchen audits done prior to the environmental health inspection on 21 March 2017 had not picked up on the failings regarding food hygiene. Following the inspection the manager had done twice daily checks.

During the inspection the manager increased auditing systems by doing a full check of areas such as kitchen performance, DNACPR's, mental capacity assessment and nutritional needs. This was following our feedback.
The provider continued to be in breach of Regulation 17 of the Health and Social Care Act 2014, good governance.

Staff told us that they were confident to approach the manager, comments included; "There have been definite improvements since the last inspection, staffing levels have increased and we are able to use agency if unable to cover shifts with own staff". "The new manager has allowed me [unit lead] to allocate my own staff, this has helped with balancing the work load for staff on duty". "The home has really improved". "The new manager has a nice approach with staff". "It is much better now the new manager is in post". And "All staff are happier".

We observed positive moral throughout the staff team and staff told us that they enjoyed working at the service.

We found the manager was familiar with people who lived at the service and their needs. When we discussed people's needs the manager showed good knowledge about the people in his care.

The manager had submitted an application to CQC to become a 'Registered Manager' for Heron Hill Care Home. A temporary clinical lead has been appointed to support the manager with clinical decisions and oversight of clinical care at the service whilst recruitment for a permanent clinical lead was on going.

We asked to look at survey results from staff, relatives, residents and external professionals. The manager told us that surveys had not been issued, however this was included in the service action plan.

The nominated individual, regional operations director and manager attended scheduled quality improvement meetings with the local authority, health commissioners and the Care Quality Commission. Regular communication had been made with commissioning and regulatory bodies in relation to progress being made at the service and any on going concerns.

We have found that the manager has been transparent in communication and had submitted statutory notifications for incidents such as the passenger lift being out of operation, serious injuries, deaths and safeguarding incidents.