Four Seasons (Evedale) Limited

Heath House

Inspection report

81 Walkers Heath Road, Kings Norton,
Birmingham, B38 OAN
Tel: 0121 459 1430
Website:

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Ratings

Overall rating for this service	Inadequate
Is the service safe?	Inadequate
Is the service effective?	Inadequate
Is the service caring?	Requires Improvement
Is the service responsive?	Requires Improvement
Is the service well-led?	Inadequate

Overall summary

The Inspection took place over three days on 10, 17 and 18 December 2014. The inspection was unannounced.

We last inspected Heath House in September 2014 when we found the provider had breached the Health and Social Care Act 2008 as it had not complied with the requirements of the Mental Health Act 2005. Following that inspection the registered manager sent us an action plan informing us of the action they would take to address the breaches we found. At this inspection in December 2014 we found that all the areas we looked at had deteriorated. We found further breaches of the Health and Social Care Act 2008 and multiple examples of how the registered provider was failing to meet the needs of the people it was supporting.

Heath House is registered to provide nursing care and support for up to 50 older people who have needs relating to their old age, dementia or on-going mental health needs. The home had recently undergone a change of management with a new home manager and deputy manager being recruited shortly before this inspection. The home manager had started the process of applying to the Care Quality Commission for registration, but at the time of our inspection there was

Summary of findings

no registered manager in post. 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.

People living at Heath House could not be confident that the registered provider would be able to keep them safe. Two people told us they did not always feel safe as they were not adequately protected and supported when other people in the home became distressed. We found the provider was not meeting people's safety needs or meeting the requirements of the law.

We observed people who were unable to move independently being supported to move by staff. Staff used a variety of techniques that had been proven to cause people harm. The staff had not all been trained to move people safely or to use the moving and handling equipment available within the home.

The home did not have enough staff in post and this meant there were not always enough of the homes own staff on duty. Sometimes the home's own staff team were supplemented by agency staff. Feedback from staff and relatives, and our own observations, showed that the staff team were not always working safely, and we saw both agency and the home's own staff demonstrating a lack of essential knowledge about people's needs and risk management and this had placed people at risk of harm.

People required help from the nursing staff to administer their prescribed medicines. We checked medicines storage, administration and the records. We did not find evidence that people had always been given the correct medicine, at the correct time in the correct dose. We found the provider was not managing people's medicines safely or meeting the requirements of the law.

New staff had not all been provided with an induction that would ensure they knew how to care for people living at Heath House and would ensure they could work safely. Staff had not all been provided with the training they required or with regular updates. This meant that their knowledge about the conditions people at Heath House experience and about safe working practices were not up to date.

The Mental Capacity Act 2005 (MCA) sets out what must be done to make sure that the human rights of people who may lack mental capacity to make decisions are protected, including when balancing autonomy and protection in relation to consent or refusal of care. The MCA Deprivation of Liberty Safeguards (DoLS) requires providers to submit applications to a 'Supervisory Body' for authority to deprive someone of their liberty. Staff at Heath House had identified some potential deprivations to people's liberty and had already made applications to the supervisory body which meant they were working in line with the Mental Capacity Act 2005 Code of Practice. The records we looked at in full did not show that people had benefitted from a full or accurate assessment of their needs or that the information about how they made decisions and the support they needed was available for staff to follow.

People did not always have a pleasant meal time experience. We could not be certain that people were being offered food that had been prepared consistently in line with the guidance given by the Dietician or the Speech and Language therapist. Staff support for people who needed help to eat changed throughout the meal, and we saw people being offered food that had gone cold, and by staff who did not engage with them or encourage them to eat. However we did see some staff working creatively to encourage people to eat, and we also staff respond promptly to one person who requested a specific food that was not on the menu. We found the provider was not always meeting people's eating and drinking needs or meeting the requirements of the law.

People living at Heath House were able to see a range of health professionals. Some health professionals and relatives told us people received good health care. We were concerned that this was not reliably the case. We found examples where people's physical and mental well-being had not been well managed and people had experienced ill health as a result. Relatives also shared examples of people's glasses, dentures and hearing aids being lost and poorly maintained. We found the provider was not always meeting people's health care needs or meeting the requirements of the law.

We spoke with nine members of staff and observed interactions between people and staff on all three days of our inspection. We saw lots of very caring and compassionate practice, and staff we spoke with all

Summary of findings

demonstrated a high regard for the people they were supporting. Some staff expressed frustration that the current staffing arrangements did not enable them to care for people in the way they would like and which would promote people's dignity. Relatives we spoke with all praised the direct care provided by staff and many were able to describe special relationships between certain staff members and their loved one. This provided them with confidence that their relative was well cared for. However we did not find that people had been consistently cared for in the way their needs required. We saw people who had not been supported to dress and undertake personal hygiene to a good standard. The skill mix of agency and regular staff on duty meant people sometimes had to wait an unduly long period of time for a member of staff with the required skills or knowledge to support them. We found the provider was not meeting people's care needs or meeting the requirements of the law.

People were able to join in a range of activities provided at Heath House. Some people had been able to maintain interests that they had before moving to the home, and other people told us they liked the entertainers and exercise groups that visited the home. For much of our inspection we observed people sleeping and there were limited opportunities for people to engage or be stimulated.

There was a complaints process in place; however evidence was not available that this was always followed. We tracked the work undertaken to investigate and resolve one recent complaint. The actions agreed by the registered manager in response to the complaint had not all been implemented and staff we spoke with were not all aware of these. This meant the person had not benefitted from an effective complaints process. We found the provider was not providing people with an effective complaints system or meeting the requirements of the law.

The management of the home had recently undergone significant change. At the time of our inspection neither the home manager nor deputy manager had been in post for long enough to fully appreciate the challenges and demands of this service. We did receive positive feedback from people, staff, relatives and health professionals that they were hopeful the new management team had the skills and knowledge required to improve the service and address the concerns identified. The governance system (ways of checking the safety and quality of the service) had not been effective, as the extent and severity of the issues identified during this inspection were not all known to the registered provider in advance of our visit. We found the provider was not providing adequate management to ensure a good quality service or meeting the requirements of the law.

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

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not safe.

People could not be certain they would be safe. The systems to ensure that adequate numbers of staff who were experienced and qualified were always available, that medicines would be given safely and that risks people presented to each other would be managed were inadequate.

Inadequate

Is the service effective?
The service was not effective.

People could not be certain they would always receive good treatment for both their physical and mental well-being needs.

People could not be certain they would receive the support they required to eat a nutritious meal suited to their needs.

People could not be certain their rights in line with the Mental Capacity Act 2005 would be identified and upheld.

Inadequate

Is the service caring?
The service was not caring.

Most individual staff demonstrated kindness and compassion but the operation of the home did not ensure that people consistently received the care they needed. The running of the service did not ensure care was always provided with dignity, or that people were as involved in their care as they wished or were able to be.

Requires Improvement

Is the service responsive?
The service was not responsive.

People were not getting individual care that met their needs.

The systems in place to listen and learn from people's experience were not effective.

Requires Improvement

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

The culture at Heath House was not empowering or inclusive.

The systems in place to check on the quality and safety of the service were not effective, and had not ensured people were benefitting from a service that met their needs.

Inadequate

Heath House

Detailed findings

Background to this inspection

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

This inspection took place over three days on 10, 17 and 18 December 2014 and was unannounced.

The inspection team comprised of three inspectors who visited at different times over the three days and an expert-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. This expert-by-experience had experience of caring for an older person themselves.

Before the inspection we looked at the information we already had about this provider. Providers are required to notify the Care Quality Commission about specific events and incidents that occur including serious injuries to people receiving care and any safeguarding matters These help us to plan our inspection and to ensure we take the necessary numbers of inspectors with the relevant skills and experiences.

During the inspection we spoke with seven people who were using the service and six relatives and friends. We used the Short Observational Tool for Inspection (SOFI) which helps us to understand what living in the care home might feel like for people who would find it hard to verbally tell us this. We interviewed nine members of staff and spoke with six health care professionals. We spoke with commissioners (the people who purchase this service). We looked at the way medicines were being administered and managed for seven people. To support our findings we looked at four people's care records and records about health and safety, staff recruitment and the records to show how quality and safety were being monitored.

Inadequate

Is the service safe?

Our findings

We asked three people if they felt safe living at Heath House. One person told us they did, and two people told us they did not. Both people told us they had felt unsettled or threatened by the behaviour of other people living at the home. During our inspection we observed behaviour similar to that which these people had described. We saw that staff were often not in the area when incidents were occurring and that when staff did witness an incident their interventions were not always effective or adequate. We saw one person communicating their distress with unsettled behaviour. Staff responded to this person's distress but told them they needed to empty some clinical waste bins before they could support them. During the time the staff were emptying the bins we saw the person's behaviour increase. One person sitting near this person started to cry and another told us they were scared. There were no staff in the area to observe this or to support any of the distressed people.

We asked to be introduced to people who were being cared for in bed. We met three people who were in bed for reasons relating to their health during our inspection. We found that all of the people had call bells in their room, but only one of three people had access to the call bell. This meant two people had no means of calling for support or assistance in the event of them being unwell or needing support from a member of staff.

Providers are required to notify the Care Quality Commission about events and incidents that occur including serious injuries to people receiving care and any safeguarding matters. We call these notifications. Before our inspection we looked at the notifications that had been sent to us. These included some incidents where people had become unsettled and hurt another person living at the home. We spoke with staff about these incidents and looked for evidence to see how the events had been reviewed and what action had been taken to reduce the likelihood of a repeat incident taking place. There were no formal systems to measure the frequency or intensity of each person's behaviour, or any recording that would enable staff to identify potential triggers. We looked at people's care plans to see how these known risks had been assessed and what plans were in place to reduce the likelihood of someone being hurt again. The plans detailed the action that staff should take following an incident but they were not pro-active in suggesting ways or strategies that would keep people safe. Staff were unable to tell us, and there were no records available to show how events had been reviewed or if the service had been developed to reduce or prevent a repeat of the same incident occurring. One visitor told us they had concerns relating to this. They told us "I've seen them [nodding at two people] argue with one another. If I see them I'll say to the agency staff that they shouldn't be together. Agency staff don't know so I'll tell them." Failing to identify, assess and manage risks relating to people's health, welfare and safety is a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 Regulation 11.

The registered provider had developed a tool for determining how many staff were required for each shift. This was based on the needs and dependency of the people living in the home. We saw this had been kept under review and updated when people's needs changed. Staff told us that there had been ongoing problems with covering shifts and that sometimes the number of staff on duty had been below the number assessed as required. The registered provider told us that the correct number of staff were always on duty but this could include both agency and the homes own staff. The home manager described the actions they had taken to address this which included offering staff extra shifts, using a staff agency as well as recruiting new nurses and carers to work at the home. We asked staff what impact the current situation had made on people living in the home. Staff told us they were able to spend less time with people, and described that basic needs were usually met, but that these were sometimes rushed and that quality activities such as talking with people had been reduced. Relatives shared with us concerns about the use of agency staff. Their comments included, "Sometimes there's a staff shortage and they have agency staff – it's confusing for them [The people living at the home]. He [my relative] does sometimes become aggressive. I do say to them try to have someone he's used to", and "They are short staffed, it often seems that way. I help. They say I don't have to but what else can I do?" We asked five members of staff about the staffing arrangements. They told us there were not always enough staff on duty. One person said, "No, not enough, as you have seen today. We've got agency staff and you never know how good or bad they are. We've had some great ones and we know that we don't have to worry about anything. But today there are two of us [permanent staff]

Inadequate

Is the service safe?

and three agency staff and we just can't do it all on our own." Failing to provide staff in suitable numbers and with suitable skills and experience is a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulation 22.

We reviewed the management of medicines within the home. Most tablets were dispensed from a monitored dosage system. We found the administration and recording of these tablets were accurate and our audit suggested that people had received their medicines dispensed from these packs as prescribed. We looked at the management of inhalers and found that the records and amount of medicine available did not match. This did not provide evidence to confirm these had been administered as often as prescribed. We were informed some people required their medicines to be hidden in their food or drinks as they might not take them. (We call this covert administration.) There was no evidence that this had been agreed to be in the person's best interest or that guidance had been sought on the best food and drink to hide the medicines in, to ensure the person received the full dose and that the medicines remained effective. We audited three people's medicine that had been prescribed to help them sleep or stay calm. Two of the three people's medicines did not balance with their records which suggested that the people had been administered more medicine than had been prescribed. We were unable to confirm that people's medicines were being safely managed and given as prescribed. This is a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulation 13.

Staff we spoke with were able to describe a range of actions they took each day to help keep people safe. These included describing safe working practices, looking for environmental hazards as well as protecting people from direct abuse. Staff we spoke with all told us that people living at Heath House were safe, and that they would be happy for a member of their family to use the service. Training records showed that not all staff had received training in safeguarding adults, and staff we spoke with were not all aware of the different types of abuse. However all staff showed a commitment to report abuse and clearly stated they would not tolerate poor practice. It was of concern that the acts of neglect we observed throughout the inspection had not been identified as such by all the staff working in the home.

We looked at the recruitment records of one recent staff starter and saw that all the required checks had been made before the person was offered a position within the home. Staff we spoke with confirmed that the necessary checks including references and a DBS check had been made.

We found that there were systems in place to ensure that the premises and equipment were managed to keep people safe. The equipment we viewed showed that it had been serviced as required. The premises we observed were well maintained and in a good state of repair.

Inadequate

Is the service effective?

Our findings

We spoke with three members of staff who had started work at Heath House within the past year. All three staff praised the welcome they received from the home's management and more established staff but described the induction process as poor. Staff comments included, "I was literally dropped in the deep end" and "I was welcomed but then expected to get on with it. I thought it was a bit bad." We asked staff if they received regular supervision. Staff told us they didn't and there were no records of regular supervision to support that these had been offered or had taken place.

The organisation had a training plan for staff working at the home. We found that training wasn't up to date. The newly appointed home manager was able to describe the actions in place to improve staff knowledge. Staff we spoke with told us that many of the courses were computer based, and these were not followed up with an assessment of competence. During the inspection we observed a range of poor manual handling practice. This was undertaken both by staff employed by the home and those provided by a local agency. We observed staff using techniques to move people that have been proven to cause injuries. This included a member of staff grabbing the top of one person's jogging bottoms and pulling them out of the dining chair and into a wheelchair. Another member of staff was helping by grabbing the person on the other side. The person looked angry and bewildered. Staff we spoke with and records we viewed showed that the manual handling training delivered had not included a practical session, or information about how to use the equipment available in the home. Staff did not have the knowledge they required to move people safely or with dignity. When we informed the provider of our findings they took action to remove the agency staff from the home, and to report the incident to the local authority as a safeguarding matter.

We asked staff about the specialist knowledge they had to meet the specific needs of people living in the home. We found that many staff had gained experience over their years working in care, but staff had not been given training or good practice guidance about the needs of people living with dementia, people who may communicate using challenging behaviour, or physical care needs such as how to reduce the risk of people getting sore skin, or how to care for someone at the end of their life. Failing to provide staff with the training, induction and support they need to undertake their work is a breach of the Health and Social Care Act 2008.(Regulated Activities) Regulation 23.

The manager described the action being taken by the home to ensure they were compliant with the requirements of the Mental Capacity Act 2005. Staff knowledge about the act and the impact it had on their work was limited, but we saw evidence that training to address this and to increase the knowledge of staff had been booked. One member of staff told us, "Yes, I've done the MCA training and DoLs. I suppose it makes us understand more about the needs of our residents and how we can help them."

Our observations identified that some people were being deprived of their liberty and the manager was able to demonstrate that this had already been identified and that applications had been made to the local authority regarding these deprivations.

We looked at the records for two people concerning their ability to make decisions and their mental capacity. The documentation had not been fully completed for either person and did not provide clear information or guidance about the support each person required to decision make concerning significant issues they may face.

People did not have free access to drinks or snacks and were reliant on staff to offer these to them. We saw that people had three meals each day and that a drinks trolley went round twice each day with a variety of drinks and biscuits. We undertook an in depth observation of one lunch time meal in one of the dining rooms. Nine people were brought into the room to eat. The mealtime was not a pleasant experience for people. Some people needed full assistance to eat their meal. During the course of the meal we saw the staff support change five times as staff got up and left the person to help someone else or to undertake another task in the dining room or home. We observed one person get up and leave their meal untouched on the table. No-one encouraged the person to return to the meal or offered them an alternative. One person was brought to the table in a special moulded chair. The person was given their roast dinner on a plate on their lap as they were unable to sit to the table. We saw the meal spill and the person struggle to get comfortable and into a position where they could eat independently. We saw four people

struggle to cut and scoop up their meals. No one was offered or provided with any adapted cutlery or crockery which would have increased their independence and the enjoyment of their meal.

We observed parts of other meal times and saw a mixture of both poor and good practice. This included observation of a member of staff trying to force a person to open their mouth by pushing a spoon against their lips. The member of staff was using a large spoon [dessert/soup spoon]. The member of staff would give the person a shake of their shoulders as if to wake them up. There was no conversation between the person and the member of staff. On another day we observed one person sleep in their chair at the dining table for the first 45 minutes of the meal. Their meal had been placed in front of them, and was uncovered and unheated. After 45 minutes we saw staff try and awake the person and feed them the meal. We observed staff offer the person two mouthfuls before we intervened and requested a fresh, hot meal be prepared for the person. At another meal we observed a member of staff engaging a resident to eat by chatting to them and encouraging them to use their fork to eat instead of their fingers. There was affection between them. We also saw staff work positively with a person who had chosen to eat only one type of food. After offering the person the menu choices they got the person the food of their preference, to ensure they had something to eat.

Some people were offered a puree meal. These meals were served on red plastic plates. This differentiated people from each other and staff were unable to explain what purpose this served. We looked to see if the puree meal had been prepared in line with guidelines written by a Speech and Language Therapist. (SALT) We found that each person's meal was prepared to the same consistency and not as directed by the SALT. Some people had been assessed as being at nutritional risk. Despite written guidelines being developed by a dietician and being available in the home meals had not been fortified and the ingredients to do this with were not available in the kitchen.

At the start of the meal cold drinks were provided at the table. These were not topped up although most people quickly finished their drinks. There was no hot drink provided or offered at the end of the meal. We observed that the tables had been set ready for a meal with a tablecloth and cutlery. We noticed however that there were no condiments, and that all the roast dinners came with gravy already added, which denied people the choice about how they would like to eat their meal. Failing to provide people with a range of suitable, nutritious foods and drinks and failing to provide the support people need to eat is a breach of the Health and Social Care Act 2008. (Regulated Activities) Regulation 14.

People living at Heath House had a complex range of health needs, relating to both their physical, emotional and mental well-being. Staff we spoke with were able to describe a range of activities they undertook each day to help people stay healthy, which included mobilising, personal care, oral care and eating and drinking.

People we met during the inspection had not all been supported to undertake their personal hygiene to a good standard. We observed people wearing dirty, ill- fitting and damaged clothes, men who had not shaved recently, people who had not been supported to brush their hair, cut their nails or to wash their hands and face. We observed people walking around in socks, with bare feet and one person with only one shoe on. There was no evidence that this was the person's preference. Staff we spoke with told us it was not always possible to support people to the extent required, and staff were unable to locate slippers or shoes. The registered provider told us that this was a reflection of people's condition, and not reflective of poor staff practice. Care plans recorded that it was the person's wish to be supported regularly with their personal care. People we spoke with were unable to tell us when they were last offered a bath or shower. We looked at records for four people. These all showed that people received a daily wash but no regular access to a bath or shower. One person's care plan stated they should be offered a bath or shower 2-3 times a week. The person had not been offered a bath or shower for the 17 days in December and had only been showered twice in November. This was contrary to their expressed wishes and requests from the person's family.

We reviewed the information we already had about this service before we started the inspection. The home had notified us about a number of pressure injuries (sore skin) which people had developed and a wound that had been referred to the local authority as safeguarding. We looked at the actions the home was taking for people who had been assessed at risk of developing sore skin. We looked at the care of three people in detail. We found one person was

Is the service effective?

getting good pressure care. One person had been assessed to be at risk of developing sore skin. On two days of our inspection we observed the person sit for long periods in the same chair. The person had not been seated on a pressure reducing cushion and the person had not been supported to change their position at regular intervals. Although this person had not developed sore skin the home were not delivering care that was in line with the person's risk assessment or care plan. The third person had developed a very serious pressure injury while at the home. When we explored this person's care we found evidence that showed the nursing staff had not taken all possible action to prevent the sore skin or to act effectively when they found it. We identified that the person had lost weight and that staff had failed to identify this and act upon the findings, and that the person had been cared for on a special bed that had not been accurately set up for them. Failing to meet this person's needs in these areas contributed to them developing a serious pressure injury. This person's care was referred to the local authority as safeguarding for further consideration. At the time of our inspection we were satisfied that the person was now receiving good care and that the injury was improving. Failing to provide people with the care they need to maintain their welfare and safety is a breach of The Health and Social Care Act 2008(Regulated Activities) Regulation 9.

The majority of people told us that they received good health care. One relative told us, "Since [my relative] has been here, she is awake more, her general health has picked up and she's eating and drinking better." We observed that some people were wearing glasses, hearing aids and dentures and people told us that the relevant professionals visited them at home to check and maintain these. Relatives we spoke with expressed some frustration at the homes ability to support people with hearing aids, dentures and glasses. One relative told us, "He's got false teeth but they've also gone in the washing and come back broken. He's had three sets all in all and they're all broken or lost. The dentist came out but he wouldn't let him do it but he's coping okay. I mean he's coping without them." We observed three pairs of glasses that had been placed on a high shelf. Staff told us they were unsure who these belonged to. We were not confident people always had the support they needed to maintain maximum independence or good health.

We met one of the Doctors who supported people living at the home. They told us that staff were usually quick to identify changes in people's health and to call for support. We spoke with six health care professionals who support people living in the home with specific healthcare needs. They also spoke of staff showing kindness and compassion to people and two of the six people unreservedly praised the home and the service offered to people. Other professionals raised concern that the team of both nurses and care staff lacked the specialist knowledge to meet the needs of the people living at the home.

Requires Improvement

Is the service caring?

Our findings

We asked staff what they did to protect people's dignity and privacy and all the staff we spoke with were able to describe how they did this. During the inspection we witnessed some of these in action, but also observed staff working inappropriately. This included feeling people's bottoms to determine if they required personal care, lifting tops and peeping down people's trousers to check on people's personal hygiene and using abbreviations of people's names, without this being their expressed preference. Relatives also reported to us that they had found their loved ones wearing pyjamas or other people's clothes without any explanation, and we were also informed by a member of staff and a relative that people had been put into bed in the wrong rooms. Failing to maintain the dignity and privacy of people using the service is a breach of the Health and Social Care Act 2008(Regulated Activities) Regulation 17.

People told us that staff were kind to them. This was a view supported by relatives we spoke with who mainly described the staff in very positive terms. Their comments included, "They [the staff] are angels" and "They are lovely. My husband can be quite challenging but they will give him a hug, talk to him and help him calm down." We heard and observed some staff involving people in their care by offering them the chance to join in an activity, for choices at meal times or to move to a different room within the home.

We spent the majority of our inspection observing the practice of staff and heard staff speaking to people kindly. On several occasions we observed people becoming upset or anxious and when staff observed this they usually reassured the person and comforted them. There were times throughout our observations when people became distressed and no staff were in the area to observe this and to subsequently provide support. People in the lounges had no means of calling for help or support when this happened. This did not enable staff to respond to their needs or anxieties quickly.

We observed some very positive work being undertaken by the activity co-ordinator to help record and display people's life history in scrap books. One person we spoke with had really enjoyed developing this and was pleased to show us a display in their bedroom that had been developed to reflect a life-long interest they had. Staff employed by the home that we spoke with, were all able to describe people's preferences and interests. This showed they had spent time getting to know people and the things and people who were important to them.

On two of the three days of our inspection we witnessed incidents where the staff team caring for a person were unsure of the person's needs or reason why care was being delivered in a certain way. We found this was because staff were working in an unfamiliar part of the home or were agency staff. We found this could have a negative impact on the person, for example one person was cared for in bed, with no clear rationale behind this. We also met relatives who were frustrated and confused by the lack of information or mixed messages from staff on duty. We observed that staff were often based in a certain room of the home and we observed wasted opportunities to spend quality time with people, as some staff purely "supervised" the room and responded to issues rather than engaged with people.

Requires Improvement

Is the service responsive?

Our findings

We looked at the action taken to deal with the most recently recorded complaint. The records available did not support that the providers own policy or expectations had been met. We looked at the actions that the home manager at the time of the complaint had agreed to put into place. These had not been adhered to. We spoke with staff about the complaint and they were not aware of the actions that had been agreed. At the time of the inspection we could not see that the care and experience of the person involved in the complaint had improved as the people responsible for direct care were not aware of changes required, and no monitoring of the complaint outcomes had taken place. During our review of care records we found a written complaint raised by a relative. This had not been dealt with as a complaint or recorded. There was no evidence this had been investigated or resolved. Failing to have an effective system to identify, receive, handle and respond to complaints is a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations, Regulation 19.

Two of the six relatives we spoke with told us they had been involved in the assessment and care planning of their relative. One relative told us," I was involved in developing [my relatives] care plan, particularly establishing family history details and background." Records we looked at showed that personal information, individual to each person had been collected and used to inform the care plan. In addition to this information about people's personal life journey had been collected by the activity co-ordinator and we were able to see how this information, supported with pictures and photos had been developed into scrapbooks to help people remember special people and important events in their lives. Permanent staff that we spoke with were able to tell us about people's individual preferences and things that would make them happy. We found staff had obtained this knowledge from spending time with people and their relatives and this was not always recorded or reflected in the written care plans. We found that the shortage of staff and the need to balance permanent staff with agency staff members meant that members of staff were not always able to utilise their skills and experiences as they were not always working with the people they knew best. Staff we spoke with were able to describe ways of person centred working but expressed their frustration that they often had to sacrifice these to ensure all the basic jobs were done when they were short staffed.

One person told us that their faith was important to them, and during the inspection we met a representative from their church who had come to worship with them. Staff told us that individuals were able to maintain their faith and those ministers could be invited to the home if people requested this.

The home offered a range of activities and for some people this included maintaining interests that they had before they moved to the home. We were informed that the home had access to transport and could take people out. People gave us mixed feedback about the activities available. One person told us, "It gets a bit boring here. I like to read a good book." Another person told us they liked it when they had been the "Resident of the day" and been supported to go out of the home for a meal. For much of our inspection we observed people sleeping and we observed limited opportunities for people to engage or be stimulated.

We observed visitors being made welcome at the home throughout our inspection. We saw that relatives were enabled and supported to provide care where they wished or for example to help a person with their meal or drink. Visitors told us there were no strict visiting times and that they were made to feel welcome and were often offered a drink.

We observed information about how to complain and raise concerns was on display around the home. Relatives we spoke with told us they had been given information about how to complain. The nurses and management staff we spoke with all showed a commitment to address concerns as swiftly and thoroughly as possible. We were informed that they operated an "open door" and would be happy to talk with visitors at any time.

Inadequate

Is the service well-led?

Our findings

We had previously inspected this home in December 2013 and September 2014. Breaches of the Health and Social Care 2010 were identified at both visits. Despite an action plan being developed following each inspection the home failed to remedy these breaches and at each inspection further breaches were identified. Our inspection did not find that the leadership, management and governance of the home had been effective. Because of this we had concerns for people's safety and we did not find that a high quality service was being provided.

We were concerned that the governance arrangements put in place by the registered provider had failed to identify the number, complexity and severity of the issues we identified during this inspection. The checks and audits in place to monitor the safety and quality of the service were inadequate. We found that records of checks and audits showed these had not been undertaken in the detail or with the frequency required by the provider or undertaken effectively to obtain a true picture of the experience of people living at the home.

The home had two nurses on duty each shift, who as well as providing clinical nursing care and support should lead and direct the care staff. Staff we spoke with told us that some delegation was undertaken each handover, but that the effectiveness of this varied according to the nurses on duty. During our inspection we saw some staff who lacked direction and some staff who were not working efficiently. In this way we could not be certain that staff fully understood their role or responsibilities. This is a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations, Regulation 10.

The home had undergone a recent change of management with a new home manager and deputy manager being recruited in the weeks prior to our inspection. The home manager had not yet applied for registration with the commission so there was no registered manager in post. Neither the manager nor the deputy manager had been in post for sufficient time to fully understand the challenges or the culture of the home, although they had both already identified some of the issues we found during this inspection. Both of the new managers showed a commitment to improving the service and an understanding of what a good service for older people should look like. Staff told us the new management team had spent time with them, finding out about their role, and areas where they felt the home needed to improve or change. Staff told us they would feel able to approach either of them if they had a matter of concern. One member of staff told us, "The new manager and deputy are great – I know I can go to them. The new manager and deputy are about the residents." The manager described plans to participate in a development and accreditation scheme for services that support people living with dementia. Staff we spoke with were keen to develop and participate in this.

At the time of our inspection we did not find evidence that Heath House was providing high quality care. Feedback from some people who used the service, some professionals and relatives was positive but other people raised concerns with us, or had done so by making complaints or sharing their experiences with us before the inspection.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations 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 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing **People who use the service were not always supported by adequate numbers of staff with the skills and experience required.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines **People who use the service could not be confident they would always receive the medicines they had been prescribed correctly or safely.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff **People using the service did not benefit from a staff team that had been inducted, trained and supported to undertake their role.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010 Meeting nutritional needs **People could not be certain they would receive the support required to maintain good nutrition and hydration.**

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services People could not be certain they would receive the care and treatment they required or that this would always be safe and appropriate.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services People using the service could not be certain their privacy and dignity would always be maintained.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA 2008 (Regulated Activities) Regulations 2010 Complaints People using the service did not benefit from an effective system by which they could make a complaint, and influence the running of the service when this was to their dissatisfaction.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse People who use services and others were not protected against the risks of being harmed as known and avoidable risks to their health and well-being were not being managed. People were not protected from the risks associated with neglect and having their care needs omitted.

The enforcement action we took:
A warning notice was issued to the provider on 14 January 2015, requiring the registered provider to have addressed these issues by February 11 2015.

Regulated activity	Regulation
	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers Systems in place to ensure people were receiving safe, effective, high quality care were inadequate to identify risks to people using the service and others.

The enforcement action we took:
A warning notice was issued to the provider on 14 January 2015, requiring the registered provider to have addressed these issues by February 11 2015.