# ALEXIS CARE LIMITED

# Heanton

## Inspection report

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## Ratings

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|---|---|
| Is the service safe? | Requires improvement |
| Is the service effective? | Requires improvement |

## Overall summary

We carried out an unannounced comprehensive inspection in October 2014. After that inspection we received concerns in relation to risks not always being managed effectively, there were not enough staff to meet the needs of the people living at the home and that essential safety works had not been completed. As a result we undertook a focussed inspection to look at those concerns. This report only covers our findings in relation to these topics. You can read the report from the last comprehensive inspection by selecting the 'all reports' link for Heanton on our website at www.cqc.org.uk . This inspection took place on 15 October 2015 and was completed by two inspectors. At the time of the inspection there were 43 people living at the service.

We found there had not always been enough staff on duty to meet the needs of people in a timely way. This was because of staff sickness. The provider was addressing this issue with recruitment of further care and nursing staff. This meant they planned to have sufficient staff and have additional hours to cover sickness, holidays and training. On the day of the inspection 11 new staff were attending an induction day. Some of the current staff group had resigned or were working their notice. This included the current registered manager, deputy manager, and two care staff. The reasons for leaving were varied, but several staff members mentioned the changes which had occurred in their shift patterns recently as being a contributing factor. The provider assured us they had already recruited an experienced manager to take up the registered manager's role.

We looked at the number of serious incidents and accidents to see if these increased when staffing levels were low. There was one date where staffing levels had been below the assessed need and the number of incidents had been high. On other days when staffing levels were lower than the assessed need, there was no evidence of an increase in incidents or accidents. This showed the risks in having decreased levels of staffing had not impacted on the safety for people, but it had

# Summary of findings

impacted on the quality and timing of care and support being provided. Staff confirmed they had not always been able to offer support in a timely way when they had been short staffed.

There had been three safeguarding alerts in the earlier part of the year and one more recently; where a person had sustained a significant injury following a fall. The person did have a care plan and risk assessment which highlighted the need for using a pressure mat to alert staff the person was moving and may need support to do this safely. The pressure mat had not been in use at the time of this fall. We were assured there was sufficient equipment for the needs of people living at the service, so there was no reason why the mat should have been removed. The registered manager had also spoken with staff about ensuring timely medical intervention being sought.

The alerts in the earlier part of the year related to poor record keeping and lack of risk assessments being in place. In one incident where a person was injured as a result of using bed sides, it was found that a risk assessment had not been in place for the use of these. During this inspection, we found there were updated risk assessments in place. The care plans were in the process of being updated onto a new computer system which should streamline the records. The current care planning documentation was difficult to navigate around and although detailed, was repetitive and not always person centred. Some of the care plan information was pre-printed and was generic. Where detailed histories and important information about the person had been recorded, care staff were not always aware of the detail of this information. A senior care staff member said this would be addressed with the introduction of the new electronic care plans, as all staff would need to access these and have input into them. Training was being organised for staff so they would be confident and competent to use the new care plan system.

Information we had received about the environment being unsafe was not substantiated. One bedroom had no flooring, but had not been in use for some months and was being refurbished as part of planned works. The electrical wiring work had been completed to ensure the system was safe and met industry standards. Further work to enhance the efficiency of the electrical wiring system was planned for completion by the end of May 2016.

# Summary of findings

## The five questions we ask about services and what we found

We always ask the following five questions of services.

**Is the service safe?**

Requires improvement

The service was not always safe. This was because there were times when staffing levels fell below what the provider had assessed as being needed to keep people safe and meet their needs. This was being addressed with recruitment and induction of new staff.

Risk assessments were in place and being reviewed, but had not always been followed, which had placed people at risk.

Staff knew understood their responsibilities to safeguard vulnerable people and to report abuse.

**Is the service effective?**

Requires improvement

The service was not always effective. People were supported by staff who were trained and supported to meet their emotional and health care needs, but some staff said they needed more specific training.

Staff did not always have the knowledge about people's social histories.

People were supported to make decisions about their care and support and staff obtained their consent before this was delivered. The manager understood their responsibilities in relation to the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards to protect people.

People were supported to access healthcare services to meet their needs.

Most people were supported to eat and drink in an unrushed and supported way.

# Heanton

**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.

We undertook an unannounced focussed inspection of Heanton on 15 October 2015. We had received concerns about staffing levels, risks to people not being managed well and safety works to the building that had not been completed. The inspection was completed by two inspectors. The team inspected the service against two of the five key questions we ask about services: is the service safe, is the service effective.

Before our inspection, we reviewed the information we held about the home, which included incident notifications they had sent us. A notification is information about important events which the service is required to tell us about by law. We reviewed the information received from the local safeguarding team as well as the services own action plan to address issues the safeguarding processes had highlighted.

During our visit we met with six people to gain their views about the care and support they received. We also spoke with two visiting relatives. We also met with five care staff, the registered manager and spoke on the phone with the nominated individual and provider. We looked at records which related to five people's individual care, including risk assessments and the staffing rotas. We reviewed data which tracked the number of accidents and incidents against the staffing levels. We checked all bedrooms and saw where new electrical works had been completed.

Following the inspection we spoke with two health care professionals.

Requires improvement

# Is the service safe?

## Our findings

We had received three anonymous concerns about staffing levels being low for the number and needs of people at the service. During the inspection we spoke with staff on duty and checked staffing rotas. We saw there had been shifts in August and September 2015 where there had been a significant shortfall of care staff for the number and needs of people at the home. There was for example, periods during some days in August and the start of October 2015 when staffing levels were at three care staff for each unit plus one nurse. The normal staff arrangements were between five and seven for each of the two units. The registered manager said that during weekdays and Saturdays, the two activities coordinators could also step into the role of care worker as they were trained in providing care and support. She also said that catering staff had also had some training in assisting people to eat and drink so could provide additional support when needed. They had tried to get agency staff and had also called existing staff to help but this was not always successful in filling the gaps where staff had called in sick. The sickness levels were not a predictable pattern so the registered manager was not able to pre-book agency or existing staff.

Staff confirmed there had been shifts where they had worked with less care staff than there should have been. Staff described these shifts as ''Challenging and demanding.'' One staff member said ''We always try to make sure people have their basic needs met, but when you are short-staffed, it does mean you have to prioritise work and some people have to wait to get up, washed and dressed.''

We concluded that there had been staff shortages due to staff sickness, which impacted on the care of people, but this was now being addressed. In the interim the provider and registered manager had agreed they would not admit any new people with complex needs until they could ensure their staffing levels and skill mix were sufficient to meet people's needs.

The provider said new staff rotas were being introduced. Some staff said this was positive as they could plan their time well in advance. Others said they thought the new proposals would cause more rigidity in staff being less willing to work flexibly. Some staff said the changes to shift patterns had impacted on staff sickness and staff leaving. The registered provider has provided further feedback following this inspection. They say rotas were now being planned well in advance and staff were getting used to working within their teams. This had resulted in less staff sickness and absences.

We looked at the number of serious incidents and accidents in relation to the staffing levels. There was one date where staffing levels had been below what the registered provider and manager had determined as needed for people's needs. On this same date the number of incidents had risen, but on other days when staffing levels were lower than the provider and registered manager had determined, there was no significant increase in incidents or accidents. We saw there was no real correlation between staffing levels and the number of incidents and accidents occurring.

The registered provider and manager said the service was being developed using a specific dementia care model. The service would be divided up into different houses, each providing for the specific needs of people with dementia, depending on their level of dementia and type of support they needed. Staff were being matched to the different houses and shift patterns had been changed to ensure coverage across the whole week. Some staff said they had found the staff rota changes had not helped staff morale or team working. Others felt it was working well. We heard from the provider how they had gone through a period of consultation with staff and had meetings to explain how their new model of care was being implemented. The providers told us they had employed key specialists to assist them in implementing the new model of dementia care across all their homes in line with current best practice. We were told that at Heanton, this process was at the beginning stages.

One relative requested to speak with us having seen the inspection poster. They wanted to say how well they felt the service was meeting their relative's needs. They said ''The staff have all been very supportive, particularly the manager. I couldn't praise the home enough. They have really been good in meeting my relative's needs.''

There had been three safeguarding alerts in the earlier part of the year and one more recently; where a person had sustained a significant injury following a fall. The nursing staff on duty at the time did not seek medical assistance as they did not feel the person was showing symptoms of having a serious injury. Since this incident, the registered manager has asked all nursing staff to ensure any

Requires improvement

# Is the service safe?

significant fall of a vulnerable person must have medical advice either via a GP visit or to the accident and emergency department. The person did have a care plan and risk assessment which highlighted the need for using a pressure mat to alert staff the person was moving and may need support to do this safely. The pressure mat had not been in use at the time of this fall. We were assured there was sufficient equipment for the needs of people living at the service, so there was no reason why the mat should have been removed.

The safeguarding alerts had been investigated by the registered manager and an action plan put in place to address issues identified. This included ensuring risk assessments and care plans were updated on a monthly basis and this was to be audited to ensure the system was effective. During this inspection, we found risk assessments were in place for key risks, such as falls, risk of pressure damage and risk of poor nutritional intake. The risk assessments had been updated on a monthly basis and where a risk had increased, actions were being taken to address this. For example, where someone had lost weight, food and fluid charts had been introduced to monitor peoples' intake. The registered manager had been auditing the care plan documentation which included risk assessments.

Staff understood the importance of ensuring they report any safeguarding concerns and were confident if they reported any, the senior team would follow up. The registered manager understood their responsibilities to report any concerns to the local safeguarding team and to the Care Quality Commission. Where alerts had been raised, they had provided a detailed action plan as to how they intended to address the issues raised within the alerts.

One healthcare professional said they had found there had been an issue around infection control with one person, which was highlighted to the registered manager and was addressed. They also felt the ''suite of documentation used for care planning were not always completed robustly.'' They did think this was being addressed with new system of care planning being introduced. There was no impact for people as staff understood people's needs and provided the care and support as assessments had identified.

We had received some anonymous information which said one bedroom was not fit for purpose and there were issues with the safety of the electrical wiring within the home. We looked at every bedroom on the day of the inspection and saw the particular bedroom mentioned in the information had no flooring. The registered manager said this was because there had been a flood in the room, but that the room had not been in use for some months. We spoke with the provider about what works had been completed in respect of ensuring the electrical wiring within the home was safe. Prior to the inspection, the provider had sent us an action plan which detailed the works carried out and those planned to be completed. The provider assured us they had worked closely with the electrical company completing the works and were confident the wiring was safe and met the industry standards. We saw some of this work had been completed on the day of the inspection and we have received further correspondence to show when the rest of the electrical works planned to enhance the efficiency of the system will be completed by the end of May 2016. This will include new TV wiring and internet access to each bedroom.

Requires improvement

# Is the service effective?

## Our findings

Some staff said they had asked for training in managing aggressive behaviour but this has not been provided or they had not attended. Following the inspection, the provider has confirmed that ''online training in managing violence and aggression has been available since March 2015 and prior to this DVD and work book training was provided. The Company have also provided additional optional online training in Conflict Resolution but so far no staff members at Heanton have requested or completed this training. 62% of the current staff group have completed this training, 15% have completed it but is has now expired, 17% of the staff are in the induction period so have not yet completed and only 6% of fully inducted staff have never completed it.''

At lunch one member of staff was persistently being sworn at by one person who became increasingly aggressive and triggered another person to start shouting. The staff member continued to be reassuring and calming in offering food to the first person. Other staff intervened and the situation was diverted. People's care files showed that not every incidence of aggressive behaviour was recorded. One senior staff member said ''Aggressive behaviour and bad language happens all the time – staff get used to it, they will calm down. We have to find ways to divert attention''. This meant the daily records may not always accurately reflect people's needs as staff had not always recorded incidents of anxiety or aggression. However when we looked at the accident and incident reports, we saw there was a high rate of reporting which was reviewed and audited to look for trends or patterns which they could learn from. We concluded the current care records were not always effective. A senior care staff member said they felt this issue would be resolved with the introduction of the new electronic care records as this would simplify where and how records were completed.

One person we spoke with alongside a care worker, talked about a number of people from their past including relatives. While the staff member was gentle and reassuring with the person they had no knowledge of the person's background. We checked the care plan and file which included a comprehensive profile picture which stated significant people in that person's past life. We asked staff whether they knew about people's background or particular interests. They said they could read the care plan but said they did not have time to so. One member of staff said ''I try to read as much as I can so that I know about people but we are very busy''. This showed some staff did not always have sufficient knowledge to fully understand the person. We were assured this would be addressed with the introduction of the new care planning system, and that all staff would have comprehensive training in being able to use this new system. This would include having time to record and read the information available.

Staff confirmed they had received supervision from their line manager on a regular basis. There were records of supervision which had been signed and dated by the staff member and the line manager.

Staff meetings were held regularly and were recorded. Meetings were held in various groupings for example, night staff, trained staff, domestic, care staff, training staff. Most recent meetings held on file were dated July 2015. Head of department meetings were held every morning with the registered manager to discuss handover and any specific incidents. Staff on the unit said they did not attend handover meetings but if there were concerns or specific issues, the senior member of staff spoke to them. This helped to ensure effective communication.

The Mental Capacity Act (2005) provides the legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision is made involving people who know the person well and other professionals, where relevant. DoLS provide legal protection for those vulnerable people who are, or may become, deprived of their liberty. The safeguards exist to provide a proper legal process and suitable protection in those circumstances where deprivation of liberty appears to be unavoidable and, in a person's own best interests.

The registered manager advised there were current DoLS authorisations in place for some people and further applications had been made for others. Staff understood the principles of ensuring people were given choices and, where possible, consent gained. For example staff made sure they talked with people about how they were going to assist them and waited for verbal consent to be given.

Records showed people had access to healthcare specialists when required. One relative confirmed their relative's health was closely monitored and the GP was called when needed. One healthcare professional said

Requires improvement

# Is the service effective?

some recent reviews had triggered further input from GPs and other healthcare professionals. They said the registered manager and nursing staff had listened to advice and support.

People were supported to eat and drink in a relaxed and unhurried way. Observations showed mostly positive experiences and interaction. However one person had been offered minimal support in the upstairs unit. The person was offered support for a very short time and then their meal was taken away. Their care plan had stated they needed encouragement to eat. We fed this back to the nurse, who assured us they would have been offered a snack or additional food later in the day when they may be more receptive. In the downstairs unit, people were offered support to eat their meal in a way which showed staff understood the need to assist at the pace of the person and to talk calmly with the person whilst support was being given.