Mr & Mrs A J Gidman

Heathfield Lodge

Inspection report

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Tel: 01515269463

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This unannounced inspection was conducted on 27 September 2016.

Heathfield Lodge care home provides accommodation and personal care for up to 26 older people. It is a large Victorian property with accommodation located over three floors. The upper floors are accessible via a passenger lift. There are two dining areas to the ground floor and a large lounge. A garden area is located at the rear of the building and parking at the front. At the time of the inspection 23 people were living at the service.

A registered manager was in post. However, the registered manager was not available on the day of the inspection. 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.

As part of the inspection process we were escorted around the building by a senior carer. We saw that some fire doors were propped open with wedges or chairs while others did not fully close.

People were placed at risk of serious injury because staff had not followed a management instruction to keep a door leading to the basement locked.

Water temperatures were not effectively monitored giving vulnerable people access to hot water at excessive temperatures.

Some people expressed concern about the safety of staffing levels at night-time.

We have made a recommendation regarding this.

Staff were safely recruited however, checks on the suitability to work with vulnerable adults had not been updated over a prolonged period. This meant that the provider could not be certain that staff were not barred from working with vulnerable adults.

We have made a recommendation regarding this.

People's medication was not always stored and administered in accordance with good practice. We spot-checked Medicine Administration Record (MAR) sheets and stock levels. In most cases stock levels were accurate and the MAR sheet completed correctly. However, one MAR sheet indicated a stock balance which was not accurate. We also saw that staff were not counter-signing when controlled drugs were administered. The service did not have protocols in place to instruct staff under which circumstances PRN (as required) medicines should be administered.

People told us that they felt safe living at Heathfield Lodge. Staff were able to explain how they helped keep people safe and made appropriate reference to training, monitoring and safeguarding procedures.

We saw evidence in care records that risk was assessed and regularly reviewed for each person living at the home. Risk was assessed in relation to; nutrition, falls, fire and pressure care.

Staff were trained in a range of subjects which were relevant to the needs of people living at the service including; infection control, administration of medicines and safeguarding adults. We saw evidence of training in staff records which indicated that all training was up to date or had been arranged.

Staff told us that they received regular supervision and appraisal from senior staff or the registered manager. We saw evidence that these meetings had taken place and that important information had been shared.

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.

The records that we saw demonstrated that the home was operating in accordance with the principles of the MCA. We saw evidence that people's capacity to consent to care had been assessed as part of the care-planning process. Some people had indicated their consent to care by signing care plans.

People told us that they were offered plenty of drinks throughout the day. We saw people being offered hot and cold drinks with their meals and throughout the course of the inspection.

The people that we spoke with had a good understanding of their healthcare needs and were able to contribute to care planning in this area. We asked people if they could access healthcare professionals when necessary. Each person said that they regularly saw healthcare professionals and attended appointments with the support of relatives and staff.

People spoke positively about the staff and their approach to the provision of care. Throughout the inspection we saw staff engaging with people in a positive and caring manner. Staff spoke to people in a respectful way and used positive, encouraging language.

People's privacy and dignity were respected throughout the inspection. Care records were stored securely and staff were sensitive to the need for discretion when discussing confidential information. We saw that staff were attentive to people's needs regarding personal care.

We saw that some people had signed documents indicating their involvement in the production of care plans. However, the evidence that people or their relatives were involved in regular reviews of care was weak.

We observed that care was not provided routinely or according to a strict timetable. Staff were able to respond to people's needs and provided care as it was required.

Information regarding compliments and complaints was displayed with a suggestion box. The people that we spoke with said that they knew what to do if they wanted to make a complaint.

We saw evidence that the registered manager and provider conducted regular audits. However, the processes had failed to identify some issues and concerns relating to the safety of the building and the administration of medicines.

Records relating to the provision of care and staffing were extensive and sufficiently detailed. However, there was a reliance on hand-written information which was sometimes difficult to read and organised differently in some files. This meant that some important information was more difficult to access than was necessary.

The provider distributed annual surveys to people and their relatives. The responses that we saw were almost 100% positive in relation to; visiting, hobbies/interests, complaints, the environment, hygiene and staffing. In response to their own findings, the provider had started a programme of refurbishment of communal areas and individual rooms. Staff told us that they and people living at the service had been involved in choosing wallpapers and colours.

People spoke positively about the registered manager and the quality of communication.

Staff understood what was expected of them. They told us that they enjoyed their jobs and were motivated to provide good quality care. We saw that staff were relaxed, positive and encouraging in their approach to people throughout the inspection.

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.

Some fire doors were wedged open or did not fully close meaning they would be less effective in the event of a fire.

Medicines were not always administered and recorded in accordance with best-practice guidelines.

Water temperatures were not effectively monitored giving vulnerable people access to hot water at excessive temperatures.

People told us that they felt safe. Staff understood safeguarding procedures and what to do if they identified any concerns.

Is the service effective?

Good

The service was effective.

Staff were trained in topics which were relevant to the needs of the people living at the service.

People were provided with a balanced diet and had ready access to food and drinks.

Staff supported people to maintain their health by engaging with external healthcare professionals.

Is the service caring?

Good

The service was caring.

We saw that people were treated with kindness and compassion throughout the inspection.

Staff knew each person and their needs and acted in accordance with those needs in a timely manner. People's privacy and dignity were protected by the manner in which care was delivered.

People were involved in their own care and were supported to be as independent as possible.

Is the service responsive?

Good

The service was responsive.

People living at the service and their relatives were not consistently involved in the planning and review of care.

The service had a varied programme of activities which were reviewed in conjunction with people living at the home.

Complaints were recorded in appropriate detail and acted on in a timely manner.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The provider had systems in place to monitor safety and quality however some issues and concerns had not been identified.

The provider sought the views of people and their staff and used feedback to develop the service.

People spoke positively about the influence of the registered manager and the general management of the service.

Heathfield Lodge

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 on 27 September 2016 and was unannounced.

The inspection was conducted by an adult social care inspector.

Before the inspection we checked the information that we held about the service and the service provider. This included statutory notifications sent to us by the registered manager about incidents and events that had occurred at the service. A notification is information about important events which the service is required to send to us by law. We used all of this information to plan how the inspection should be conducted.

We observed care and support and spoke with people living at the home and the staff. We also spent time looking at records, including four care records, four staff files, medication administration record (MAR) sheets and other records relating to the management of the service. We contacted social care professionals who had involvement with the service to ask for their views.

On the day of the inspection we spoke with four people living at the home, one relative and one other visitor. We also spoke with two senior carers, the cook and three other staff. Following the inspection we spoke with a senior manager for the service.

Requires Improvement

Is the service safe?

Our findings

Essential safety checks, for example, gas safety and electrical safety were completed in accordance with the relevant schedule by suitably qualified external contractors. The service also completed its own checks. For example, emergency lighting, fire alarms and water temperatures. We saw that the water temperatures recently recorded were identical at every hot water outlet. None of the water outlets that we saw had a thermostatic mixing valve in place. This meant that it would be extremely difficult to maintain safe, consistent hot water temperature's at each outlet because the taps were different distances from the source. We checked the temperature at two different hot water outlets by letting them run and placing a hand under the hot water. The activity quickly became uncomfortable indicating that the hot water was at an excessive temperature. People with certain health conditions, including skin integrity issues are at risk of harm from access to water at high temperatures. We spoke with a senior manager about this and were told that additional checks had been completed and the temperatures had been found to be higher than previously recorded in some areas. The boiler was subsequently adjusted to ensure that vulnerable people could not access water at high temperatures.

This is a breach of Regulation 12(2) (d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's medication was not always stored and administered in accordance with good practice. The majority of medicines were provided by a local pharmacy using a recognised blister-pack system. Other medicines were provided in boxed form. We spot-checked Medicine Administration Record (MAR) sheets and stock levels. In most cases stock levels were accurate and the MAR sheet completed correctly. However, one MAR sheet indicated a stock balance which was not accurate. We spoke with a senior carer about this, but we could not find a clear explanation for the discrepancy. We also saw that staff were not counter-signing when controlled drugs were administered. Controlled drugs are prescription medicines that have controls in place under the Misuse of Drugs Act and associated legislation. We saw evidence that staff had recently stopped countersigning. We were told that this was done on the recommendation of a visiting healthcare professional.

PRN (as required) medicines were supported by basic guidance to ensure that they were administered safely. PRN medicines are those which are only administered when needed for example for pain relief. The service did not have protocols in place to instruct staff under which circumstances PRN medicines should be administered. This meant that people who were unable to communicate their need for PRN medicines might not receive them in a timely, effective manner.

This is a breach of Regulation 12(2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We were told that nobody currently living at the home required covert medicines. These are medicines which are hidden in food or drink and are administered in the person's best interest with the agreement of the prescriber.

A full audit of medicines and records was completed monthly.

As part of the inspection process we were escorted around the building by a senior carer. We saw that some fire doors were propped open with wedges or chairs while others did not fully close. Fire doors are only effective in limiting the spread of fire when they provide a good seal with the door frame. We asked the senior carer about the practice of wedging doors open and were told that some people were restricted to bed because of their health conditions. Staff and managers had agreed that it was safer to keep doors wedged open so that they could regularly observe people in their rooms. In other parts of the building automatic closure devices were fitted to fire doors. We also asked about the fire doors that did not fully close. We were told and saw evidence that new smoke seals had been recently fitted to some of the doors following guidance from the fire service. The installation of the smoke seals meant that some doors did not fully close automatically as required. We spoke with a senior manager following the inspection and received assurances that all fire doors would be checked for effective closure and fitment as a priority. We also received confirmation that the risk assessments relating to people who are confined to bed would be reviewed to ensure that they were safe in the event of a fire and automatic closure devices would be fitted where appropriate. The service had produced a general evacuation plan and some care records contained personal emergency evacuation plans (PEEPS). The service had also conducted regular fire drills and fire alarm testing. Fire safety equipment was tested by external contractors annually and by the home on a regular basis.

During the inspection we saw a document that contained a clear instruction to staff to keep the doors at the end of the main hallway locked at all times to reduce the risk of anyone falling down the stairs to the basement. When we were escorted around the building we saw that the door at the far end of the hallway was not locked. We alerted the senior carer to this and the door was locked immediately. We spoke with the senior carer and a senior manager about this and were assured that staff would be reminded of the importance of keeping both doors locked.

Staffing numbers were adequate to meet the needs of people living at the service during the day. A minimum of four care staff were deployed on each daytime shift. This reduced to two staff overnight. Additional staff included a cook, a domestic and a maintenance person. Some people expressed concern that night-time staffing levels would not be sufficient in the event of an emergency. For example, if the building needed to be evacuated or somebody required support to attend hospital. We spoke with a senior manager about this and were told that additional support was available from the proprietors and other senior staff who lived locally. The provider based staffing allocation on the completion of an initial assessment of needs. We were told that following comments from staff, an additional carer had been deployed on each of the day-time shifts. We were also told that the service had deployed an additional member of staff overnight, but that the practice had been stopped because it was not financially viable.

We recommend the service reviews the deployment of staff to ensure that there are sufficient at all times to provide safe, effective care.

Staff were recruited following a robust procedure. Staff records contained a minimum of one reference, photographic identification, an application form and an induction checklist. There were Criminal Records Bureaux (CRB) or Disclosure and Barring Service (DBS) numbers and proof of identification on each file. DBS checks are completed to ensure that new staff are suited to working with vulnerable adults. However, there was no system in place to establish if the DBS status of staff had changed since the original application. Some the checks were in excess of 10 years old. This meant that the service could not be certain that its staff were not barred from working with vulnerable adults.

We recommend that the service reviews its procedures relating to DBS checks to ensure that all staff remain suited to working with vulnerable adults.

People told us that they felt safe living at Heathfield Lodge. One person commented, "Safe, oh yes." While another said, "I feel safer here than any house I've lived in." The visitors that we spoke with were positive about the safety of the service. One person said, "There seem to be plenty of staff." Another person told us, "[relative] is safe in the way they're cared for." Staff provided practical examples of how they helped to keep people safe. One member of staff said, "We checked their rooms regularly and assist people when they need it. We've had safeguarding training this week so I know what to look for."

Staff were able to explain how they helped keep people safe and made appropriate reference to training, monitoring and safeguarding procedures. We asked people living at the home what they would do if they were being treated unfairly or unkindly. They each said that they would complain to the registered manager or another member of staff. Relatives and visitors also told us that they would speak to the registered manager if they had any concerns. The training records showed that all staff had received recent training in adult safeguarding. Staff knew how to recognise abuse and discrimination.

We saw evidence in care records that risk was assessed and regularly reviewed for each person living at the home. Risk was assessed in relation to; nutrition, falls, fire and pressure care. Accidents and incidents were accurately recorded, sufficiently detailed and included reference to actions taken following accidents and incidents. However, there was no indication that records had been checked to see if there were any patterns or lessons to be learnt.

Good

Is the service effective?

Our findings

People told us that they felt the staff were competent to deliver their care. One person living at the service told us, "Staff know what they're doing." While a family member said, "Staff have the right skills to meet [relative's] needs." The staff that we spoke with were very positive about the training that they received and told us that they felt well-equipped to meet people's needs.

Staff were trained in a range of subjects which were relevant to the needs of people living at the service including; infection control, administration of medicines and safeguarding adults. Training was primarily facilitated by external, specialist providers. We saw evidence of training in staff records which indicated that all training was up to date or had been arranged. Staff were also encouraged to complete additional training. For example National Vocational Qualifications (NVQ). A member of staff said, "I've got two more to go then I'm up to date with my training. I've done my NVQ level 2 here." We saw evidence that 12 of the 26 staff had secured a qualification at level 2 or 3. We asked a senior support worker to describe the process for the induction of new staff. They described a process which meant that new staff were inducted according to the principles of the care certificate. The care certificate requires new staff to complete a programme of training, be observed in practice and then signed-off as competent by a senior colleague. However, the records of induction were not robust and did not clearly demonstrate that the principles had been adhered to.

Staff told us that they received regular supervision and appraisal from senior staff or the registered manager. We saw evidence that these meetings had taken place and that important information had been shared. One member of staff said, "We get supervision every three months." Staff told us that they were well-supported by the registered manager.

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).

The records that we saw demonstrated that the home was operating in accordance with the principles of the MCA. We saw evidence that people's capacity to consent to care had been assessed as part of the care-planning process. Some people had indicated their consent to care by signing care plans.

As part of the inspection process we ate lunch with people living at the service. Meals were served in a well presented dining room. Tables were laid out with table cloths, matching crockery and cutlery. The food was well presented and nutritionally balanced. People's preferences, allergies and health needs were recorded

and used in the preparation of meals, snacks and drinks. We saw that instructions for the preparation of meals and drinks made reference to people's preferences. For example, we saw that one person preferred their drinks to be served in a china cup. People spoke positively about the food and the choice that was offered. The home operated a three week rolling menu with a choice for each course. However, the menu was not clearly displayed. People were asked each day about their preference by the cook or a member of the care staff. Each of the people that we spoke with confirmed that they could ask for an alternative. People told us that they were offered plenty of drinks throughout the day. We saw people being offered hot and cold drinks with their meals and throughout the course of the inspection.

The people that we spoke with had a good understanding of their healthcare needs and were able to contribute to care planning in this area. Some people had identified a named relative to communicate with. We asked people if they could see healthcare professionals when necessary. Each person said that they regularly saw healthcare professionals and attended appointments with the support of relatives and staff. One relative said, "They have a district nurse come in every week. They [staff] do something about it if [relative] needs help." We saw records of these visits on care files. The home also had access to an electronic system for contacting healthcare professionals for advice.

Good

Is the service caring?

Our findings

People spoke positively about the staff and their approach to the provision of care. One person living at the home said, "The staff speak nicely to me." While another person told us, "I know all of the staff by their first names. They know me well." Another person commented, "They're all very good to me. I'm happy and feel safe." A relative said, "Oh yes. Staff are very caring and speak to [relative] well."

Throughout the inspection we saw staff engaging with people in a positive and caring manner. Staff spoke to people in a respectful way and used positive, encouraging language. Staff took time to listen to people and responded to comments and requests. We saw that staff had time to speak with people as well as completing their care tasks. Staff demonstrated that they knew the people living at the home and accommodated their needs in the provision of care. For example, when we asked staff which people would be most comfortable speaking with us, they were able to explain who would enjoy speaking to us most and what their level of understanding was likely to be. In each case we saw that they explained the purpose of the discussion well and encouraged people to take part.

People living at the home that we spoke with said that they were encouraged and supported to be as independent as possible. A family member said, "[relative] has brightened-up in the last few weeks. [Relative] is weight-bearing again." Another person told us, "I wash and dress myself." We saw that people declined care at some points during the inspection and that staff respected their views. For example, one person was asked if they wanted to join a group to watch a film. They told staff that they would rather go to their room and were escorted to do so.

People's privacy and dignity were respected throughout the inspection. Care records were stored securely and staff were sensitive to the need for discretion when discussing confidential information. We saw that staff were attentive to people's needs regarding personal care. People living at the home had access to their own room with washing facilities for the provision of personal care if required. The home also had shared bathing and showering facilities. When we spoke with staff they demonstrated that they understood people's right to privacy and the need to maintain dignity and choice in the provision of care. One member of staff told us, "We shut doors when we do personal care and cover people where you can." Another member of staff said, "We knock before we go in to people's rooms or the toilet. We give people choices about clothing."

We spoke with a visitor and a relative during the inspection. They told us that they were free to visit at any time. People living at the home confirmed that this was the case. Relatives made use of the communal areas, but could also access people's bedrooms for greater privacy.

The home had information about independent advocacy services. We were told that two people were currently using advocacy services. We saw from care records that people were able to advocate for themselves or had nominated a family member to act on their behalf.

Good

Is the service responsive?

Our findings

We asked people and their relatives if they had been involved in their care planning and reviewing care needs. Some people explained how they had been involved and what changes had been made as a result. We saw that some people had signed documents indicating their involvement in the production of care plans. However, the evidence that people or their relatives were involved in regular reviews of care was weak. We spoke to staff about this and were assured that people were invited to the annual reviews of care held in conjunction with health and social care professionals, but there was an acknowledgement that monthly reviews of care did not consistently include the people living at the service. This meant the service could not be certain that care plans accurately reflected people's current needs and preferences.

People's rooms were filled with personal items and family photographs. We saw from care records that some people's personal histories and preferences were recorded. We saw that staff used personal knowledge in conversations with people. For example, one member of staff talked about a person's interest in drawing and painting as a distraction when they were becoming anxious.

We observed that care was not provided routinely or according to a strict timetable. Staff were able to respond to people's needs and provided care as it was required. We asked people living at the home if they had a choice about who provides their care. None of the people that we spoke with expressed concern about their choice of carers. However, we were told that the provision of personal care was usually kept to the same gender.

We saw a record of group activities which included; guest entertainers, exercise sessions, music, films and quizzes. Some of the activities were recorded as, 'requested by residents.' The records contained a basic evaluation of previous activities. Staff were honest about the difficulty they had in motivating some people to join-in the activities. People were also supported on an individual basis. For example, one person had a preference for a particular genre of film and was supported to watch them on the large screen TV in the lounge. Another person was supported to access the garden to draw and paint.

Information regarding compliments and complaints was displayed with a suggestion box. The people that we spoke with said that they knew what to do if they wanted to make a complaint. A relative said, "I'd speak to [registered manager] or [senior carers]." There were a small number of complaints recorded in the previous 12 months. Each one detailed what action had been taken in response.

Requires Improvement

Is the service well-led?

Our findings

A registered manager was in post. However, the registered manager was not available on the day of the inspection. Management of the service was provided by the senior carers. The registered manager subsequently provided additional information to support the inspection.

The senior carers dealt with the questions and issues arising out of the inspection process openly and honestly. They were able to provide the majority of information and evidence on request and responded in an effective and timely manner when concerns were identified. We saw evidence that the registered manager and provider conducted regular audits. However, the processes had failed to identify some issues and concerns relating to the safety of the building and the administration of medicines. It was subsequently confirmed that issues relating to improvements in fire safety were being completed in accordance with an action plan issued by the Merseyside Fire and Rescue Service. The medicines' stock error occurred in between the regular medicines' audits. The registered manager was confident that it would have been identified and addressed by the audit process. They further confirmed that audit processes had been revised to ensure that other essential safety information was recorded accurately.

The home maintained records of notifications to the Care Quality Commission and safeguarding referrals to the local authority. Each record was detailed and recorded outcomes where appropriate. Records relating to the provision of care and staffing were extensive and sufficiently detailed. However, there was a reliance on hand-written information which was sometimes difficult to read and organised differently in some files. This meant that some important information was more difficult to access than was necessary.

People living at the service and staff were regularly consulted about the service through resident and relative meetings and staff meetings. We saw evidence that information was provided at these meetings and people's views were sought. For example, at the meeting on 22 July 2016 suggestions were submitted about food, drink and activities. There was also a reference made for relatives about an open-door policy regarding communication, concerns and complaints for those who couldn't always attend meetings. The provider distributed annual surveys to people and their relatives. The responses that we saw were almost 100% positive in relation to; visiting, hobbies/interests, complaints, the environment, hygiene and staffing. In response to their own findings, the provider had started a programme of refurbishment of communal areas and individual rooms. Staff told us that they and people living at the service had been involved in choosing wallpapers and colours.

The home had an extensive set of policies and procedures. Policies included; adult safeguarding, MCA and person-centred care. Policies were detailed and offered staff guidance regarding expectations, standards and important information.

People spoke positively about the registered manager and the quality of communication. One relative said, "[registered manager] is pretty good. She'll sort things out. She runs quite a tight ship." While a member of staff commented, "The home is well-managed and well-led. I get told everything that's going on."

Staff understood what was expected of them. They told us that they enjoyed their jobs and were motivated to provide good quality care. We saw that staff were relaxed, positive and encouraging in their approach to people throughout the inspection. One member of staff said, "We feel motivated and happy to do our jobs. I know what is expected of me. I get a [new] employee handbook every 12 months I love my job." While another member of staff told us, I really enjoy my job. I think of the residents as family."

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 will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were given access to water at excessive temperatures. Medicines were not always administered safely in accordance with best practice.