Four Seasons (Bamford) Limited

The Heights Care Home

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

We carried out an unannounced inspection of the service on 12 December 2016. The Heights is registered to provide accommodation and nursing care for up to 36 older people, with a range of medical and age related conditions, including arthritis, frailty, mobility issues, diabetes and dementia. On the day of our inspection 33 people were using the service, including one person receiving respite care and one person who was being treated in hospital.

The previous inspection was carried out on the 8 and 13 April 2015, when shortfalls were identified and the service was found to require improvement regarding person centred care and staff support and training. Following that inspection, we asked the provider to send us an action plan to say how they would address these issues. During our latest inspection we found the necessary improvements had been made.

There was a registered manager in post, although not able to be present 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.

Staff training was inconsistent and did not always ensure staff had the necessary knowledge, confidence and competence to effectively meet people's needs. People were not consulted or consistently involved in decisions regarding what they eat or drink.

There were policies and procedures in place to assist staff on how keep people safe and individual risk assessments were kept up to date. Staff told us they had completed training in safe working practices. We saw people were supported with patience, consideration and kindness and their privacy and dignity was respected.

Staff were deployed in sufficient numbers to ensure people received safe and personalised care and support. Staff received one-to-one supervision meetings with their line manager. Formal personal development plans, such as annual appraisals, were in place.

People's needs were assessed and their care plans provided staff with clear guidance about how they

wanted their individual needs met. Care plans were person centred and contained appropriate risk assessments. They were regularly reviewed and amended as necessary to ensure they reflected people's changing support needs. People were able to access health, social and medical care, as required.

Thorough recruitment procedures were followed and appropriate pre-employment checks had been made including evidence of identity and satisfactory written references. Appropriate checks were also undertaken to ensure new staff were safe to work within the care sector.

Medicines were managed safely in accordance with current regulations and guidance by staff who had received appropriate training to help ensure safe practice. There were systems in place to ensure that medicines had been stored, administered, audited and reviewed appropriately.

The registered manager and staff had received training in the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). In accordance with the principles of the MCA, people were supported to make decisions in their best interests.

People were provided with appropriate food and drink to meet their health needs and were happy with the food they received. People's nutritional needs were assessed and records were accurately maintained to ensure people were protected from risks associated with eating and drinking. Where risks to people had been identified, these had been appropriately monitored and referrals made to relevant professionals, where necessary.

There were quality assurance audits and a formal complaints process in place. People were encouraged and supported to express their views about their care and staff were responsive to their comments. Satisfaction questionnaires were used to obtain the views of people who lived in the home, their relatives and other stakeholders.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Staffing levels were sufficient and helped ensure people received a safe level of care. Medicines were stored and administered safely and accurate records were maintained. People were protected by robust recruitment practices, which helped ensure their safety. Concerns and risks were identified and acted upon.

Is the service effective?

Requires Improvement

The service was not always effective.

Inconsistent training methods did not ensure staff always had the knowledge, confidence and competence to carry out their roles and responsibilities. People were not consistently involved in decisions about what they eat and drink. Staff had training in relation to the Mental Capacity Act (MCA) and had an understanding of Deprivation of Liberty Safeguards (DoLS). Capacity assessments were completed for people, as needed, to ensure their rights were protected. People were able to access external health and social care services, as required.

Is the service caring?

Good

The service was caring.

People and their relatives spoke positively about the kind, understanding and compassionate attitude of the registered manager and care staff. Staff spent time with people, communicated patiently and effectively and treated them with kindness, dignity and respect. People were involved in making decisions about their care. They were regularly asked about their choices and individual preferences and these were reflected in the personalised care and support they received.

Is the service responsive?

Good

The service was responsive.

Staff had a good understanding of people's identified care and support needs. Individual care and support needs were regularly assessed and monitored, to ensure that any changes were accurately reflected in the care and treatment people received. A complaints procedure was in place and people told us that they felt able to raise any issues or concerns.

Is the service well-led?

Good

The service was well led.

Staff said they felt supported by the registered manager. They were aware of their responsibilities and felt confident in their individual roles. There was a positive, open and inclusive culture throughout the service and staff shared and demonstrated values that included honesty, compassion, safety and respect. People were encouraged to share their views about the service and improvements were made. There was an effective quality monitoring system to help ensure the care provided reflected people's needs.

The Heights Care Home

Detailed findings

Background to this inspection

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

The inspection took place on 12 December 2016 and was unannounced. The inspection team consisted of one inspector, a specialist nurse advisor 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. They had experience of a range of care services.

We looked at notifications sent to us by the provider. A notification is information about important events which the provider is required to tell us about by law. We asked the service to complete a provider information return (PIR). This is a form that asks the provider to give us information about the service, what they do well, and what improvements they are planning to make. This was returned to us by the service.

On the day of the inspection we spoke with eight people who used the service, six relatives and a visiting health care professional, regarding their experience of the service. We also spoke with five members of the care staff, the clinical lead nurse, the 'residents' experience lead' (a senior member of staff with specific responsibility for monitoring people's experiences of care), the regional manager and the deputy manager. Throughout the day, we observed care practice, the administration of medicines as well as general interactions between the people and staff.

We looked at documentation, including four people's care and support plans, their health records, risk assessments and daily notes. We also looked at three staff files and records relating to the management of the service. They included audits such as medicine administration and maintenance of the environment, staff rotas, training records and policies and procedures

Good

Our findings

People said they felt safe and comfortable at The Heights. Relatives we spoke with had no concerns regarding the safety and welfare of their family members. However we did receive some comments regarding people having to wait for call bells to be answered. One person told us, "There is always someone on duty to help if necessary but they sometimes take their time coming to answer the buzzer." Another person told us, "It's much safer here than being at home; the staff come straight away if you need them, but they are sometimes rushed off their feet." A relative we spoke with told us, "We know my [family member] is safe here. After having two falls earlier this year, [family member] has had a monitor fitted, so we know they [care staff] are looking after her."

People we spoke with felt there was generally enough staff available to support them. One person told us, "I do get help, but I think that sometimes they need more help upstairs. I sometimes have to wait if they're busy." Another person said, "I don't have to wait too long, it depends how many are on, but they do their best." The regional manager told us staffing levels were regularly monitored and were flexible to ensure they reflected people's current dependency levels. They said staffing levels were also reassessed whenever an individual's condition or care and support needs changed, to ensure people's safety and welfare.

Throughout the day we observed positive and friendly interactions. People were comfortable and relaxed with staff, happily asking for help, as required. We also saw people were free to move around both floors and had choice about which lounge they liked to sit in and which dining room they preferred to use. There was a passenger lift (reinstated since the previous inspection) that provided easy access to both floors, which meant people were able to move safely around the premises.

Medicines were managed safely and consistently. Staff involved in administering medicines had received appropriate training. We spoke with the clinical lead nurse regarding the policies and procedures for the safe storage, administration and disposal of medicines. They confirmed that, "The safety of the residents here is paramount. Everyone with responsibility for medication has had the necessary training and their competency is regularly assessed." This was supported by training records we were shown.

During lunchtime we observed medicines being administered and saw that all medication administration records (MAR) had been completed appropriately. Staff gave out medicines to people just after lunch. They demonstrated safe and courteous practice and we heard they asked people for consent. Staff also explained to people what their medicine was for. For example, we heard them say, "[Name] I have your tablet here for your blood pressure. Is it okay to give you your medication now?" Fridge temperatures for storing medicines

were appropriately recorded and monitored in accordance with professional guidance and best practice. This helped ensure medicines were stored, handled and administered safely.

The provider operated safe and thorough recruitment procedures. We found appropriate procedures had been followed, including application forms with full employment history, relevant experience information, eligibility to work and reference checks. Before staff were employed, the provider requested criminal records checks through the Government's Disclosure and Barring Service (DBS) as part of the recruitment process. The DBS helps employers ensure that people they recruit are suitable to work with vulnerable people who use care and support services.

During our inspection we saw all areas of the premises were clean, well-maintained and easily accessible. Contingency plans were in place in the event of an unforeseen emergency, such as a fire. Maintenance and servicing records were kept up to date for the premises and utilities, including water, gas and electricity. Maintenance records showed that equipment, such as fire alarms, extinguishers, mobile hoists, the call bell system and emergency lighting were regularly checked and serviced in accordance with the manufacturer's guidelines.

People were protected from avoidable harm as potential risks, such as falls, had been identified and assessed, to help ensure they were appropriately managed. In care plans we looked at, we saw personal and environmental risk assessments were in place. People told us they had been directly involved in the assessment process and we saw this was recorded in individual care plans.

Staff we spoke with said they understood what constituted abuse and were aware of their responsibilities in relation to reporting this. They told us that because of their training they were far more aware of the different forms of abuse and were able to describe them to us. Staff had completed training in safeguarding adults and received regular update training. This was supported by training records we were shown. Staff also told us they would not hesitate to report any concerns they had about care practice and were confident any such concerns would be taken seriously and acted upon. We saw where safeguarding referrals were required they had been made appropriately and in a timely manner. Training records we looked at showed staff had received safeguarding training and regular updates to ensure they remained up to date with any changes in procedures.

The deputy manager told us all incidents and accidents were monitored to identify any themes or patterns which may indicate a change in people's needs, circumstances or medical condition. They said this helped reduce the potential risk of such accidents or incidents happening again and we saw documentary evidence to support this. This demonstrated a culture of learning lessons and a commitment to ensure the safety and welfare of people who used the service.

Requires Improvement

Our findings

People and their relatives thought staff had the necessary skills and knowledge to effectively meet people's individual care and support needs. One person told us, "The staff here all seem to know what they're doing – and they do a good job." People had access to doctors and other health care professionals, as and when required. One person told us, "You can see a doctor when you want and the optician and chiropodist are here fairly regularly." We saw in people's care plans that they had regular access to healthcare professionals, such as GPs, speech and language therapists, podiatrists and dentists. Individual care plans also contained records of any appointments with, or visits from, such healthcare professionals.

However staff we spoke with raised some concerns regarding the limited range of training provision, particularly the 'disproportionate' use of on-line training (e-learning). One member of staff told us. "I'm not a massive fan of e-learning; we do a lot of it here and some of it is very generic. For example a session we had on dealing with anaphylactic shock said to administer adrenaline – and we wouldn't do that, we would just call 999."

This was a view shared by many of the staff we spoke with who said they preferred the face-to-face training, which gave them the opportunity to ask questions and share experiences. Another member of staff told us, "With e-learning everyone passes eventually because you can just keep on doing it until you get the necessary mark." We also found the level of dementia awareness amongst staff we spoke with was inconsistent, with some feeling "unsafe" and "not always confident" when dealing with certain situations and behaviour that challenged. The concerns regarding e-learning were reinforced by a qualified nurse we spoke with who told us, "For our validation, we can't just sit in front of a computer, print out a certificate and say we've done it. We need to be seen to do it, but with this, there is no effective competency assessment." This meant people were supported by staff who did not always feel confident in their roles and demonstrated a need for more service specific, thorough and effective staff training.

We discussed these issues with the regional manager who told us the registered manager had qualified as a 'care coach' and staff training was currently being reviewed in line with Skills for Care. They said that phase one of this process had focussed on new staff, employed after April 2015 and phase two will cover all staff employed before that date, to ensure standardisation. They also assured us this "overhaul" would include addressing current training methods and would hopefully "get the balance right." The regional manager also advised us that specialist dementia awareness - Dementia Care Framework (DCF) - training, was being rolled out throughout the organisation. They said it was proposed that all staff at The Heights would be receiving the training early in 2017.

Staff received regular supervision and annual appraisals and the dates for these individual sessions were displayed in the office. We saw the nurses received clinical supervision, which provided a safe and confidential environment to reflect on and discuss their professional work.

We saw staff assessed people's risk of malnutrition using a malnutrition universal screening tool (MUST). These assessments were reviewed monthly which meant staff could monitor people's conditions and take action when necessary. However we identified some concerns regarding the catering arrangements and how people were supported to have sufficient to eat and drink and maintain a balanced and nutritious diet.

The Heights used a company of outside caterers, who were contracted to provide meals for people using the service. The regional manager explained that the chef and the kitchen staff were employed by the contractor and the chef moved between sites, within the organisation .However the deputy manager told us that, other than the occasional discussion during a residents' meeting, there was no formal consultation with people about their dietary likes, dislikes and preferences. They said there was a four-week rolling menu, supplied by the head office, which the chef followed.

We received less than positive comments from people, regarding the quality of the food provided. One person told us, "I think they just warm the food up - It's [not at all good] and you never get a joint on a Sunday. They need to change their menus " Another person told us, "I have rowed with [catering staff] over the food here and have made a complaint to the manager - and my son has phoned the catering company up." This meant people were not effectively consulted or involved in decisions regarding what they eat or drink.

We observed lunch in the first floor dining area and saw meals were served by the chef off the trolley they had brought up from the kitchen. We saw that, where necessary, appropriate and discreet support with eating was provided by staff in a calm, unhurried manner. A copy of the menu was displayed in all the dining areas and we saw people were offered a variety of specialist diets, including diabetic and pureed meals, to meet their individual needs.

The deputy manager confirmed a GP from the local surgery visited the service each Monday and carried out a "weekly ward round." They added that prior to this; they would email the surgery with the names of anyone who needed to be seen, either because of their condition or possibly to review their medicine.

During our inspection we spoke with the GP who said they had confidence in the registered manager and staff team at The Heights and had no concerns regarding the standard of care people received. They had been aware of some instances in the past when agency staff were employed, which had been unsettling. However they felt this situation had now settled down and a more stable staff team had helped ensure more consistency and continuity of care. They said staff seem to know and understand people much better now and were therefore much more aware of their care and support needs.

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 Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. These safeguards protect the rights of people by ensuring if there are any restrictions to their freedom and liberty these have been authorised by the local authority as being required

to protect the person from harm. The deputy manager confirmed that, following individual assessments, DoLS authorisations were in place for two people. They also told us they were currently waiting for decisions regarding further DoLS authorisations, following applications to the local authority.

Staff we spoke with had knowledge and understanding of the Mental Capacity Act (MCA) and had received training in this area. We saw people were given choices in the way they wanted to be cared for. People's capacity was considered in care assessments so staff knew the level of support they required while making decisions for themselves. If people did not have the capacity to make specific decisions around their care, staff involved their family or other healthcare professionals as required to make a decision in their 'best interest' in line with the Mental Capacity Act 2005. A best interest meeting considers both the current and future interests of the individual who lacks capacity, and decides which course of action will best meet their needs and keep them safe. Staff also described how they carefully explained a specific task or procedure and gained consent from the individual before carrying out any personal care tasks. People confirmed staff always gained their consent before providing any personal care.

Good

Our findings

People and their relatives we spoke with were positive about the staff. One person told us, "The staff are lovely, they respect and care for us." A relative told us that their family member was well looked after and they had, "Absolutely no concerns," regarding the kindness of the staff.

Communication between staff and the people they supported was sensitive and respectful and we saw people being gently encouraged to express their views. We observed staff involved and supported people in making decisions about their personal care and support. Relatives confirmed that, where appropriate, they were involved in their care planning and had the opportunity to attend care plan reviews. They also said they were kept well-informed and were made welcome whenever they visited.

Throughout the day we observed many examples of friendly, good natured interaction. A member of staff described how people were encouraged and supported to take decisions and make choices about all aspects of daily living. These choices were respected. We saw and heard staff speak with people in a calm, considerate and respectful manner; they were patient with people, and took the time to check that individuals had heard and understood what they were saying. This demonstrated the kind, caring and supportive attitude and approach of the staff.

Individual care plans we looked at contained details regarding people's personal history, their interests, likes and dislikes. The information and guidance enabled staff to meet people's care and support needs in a structured and consistent manner. Staff had a good understanding of people's needs; they were aware of their personal preferences and supported people in the way they liked to be cared for.

People had their dignity promoted because the registered manager and staff demonstrated a strong commitment to providing respectful, compassionate care. The deputy manager told us people were treated as individuals and supported, encouraged and enabled to be as independent as they wanted to be. During our inspection we observed staff were sensitive and respectful in their dealings with people. They knocked on bedroom and bathroom doors to check if they could enter.

People's wishes regarding their religious and cultural needs were respected by staff who supported them. Within individual care plans, we also saw personal and sensitive end of life plans, which were written in the first person and clearly showed the person's involvement in them. They included details of their religion, their next of kin or advocate, where they wished to spend their final days and funeral arrangements.

Good

Our findings

People had their needs assessed prior to moving to the service. They received personalised care from staff who were aware of and responsive to their individual care and support needs. One person told us, "I can always choose what I like to do." People also spoke very positively about the activities co-ordinator, who was clearly well-liked and popular. Relatives we spoke with told us the home was very welcoming and there were no restrictions on visiting times. One relative told us they had been involved in the development and reviewing of their family member's care plan.

The 'residents' experience lead' told us, in accordance with people's wishes, the service worked hard to develop and maintain effective links with the local community. During our inspection we observed a good example of this when children from a local school visited and brought with them Christmas wreaths they had made, to decorate people's bedroom doors. People were clearly happy to see the children and, although their visit coincided with lunchtime, we saw some friendly good natured interactions between them.

We spoke with the activity coordinator, who told us they covered seven days a week and offered people a range of events, including both group and individual activities. They said people could choose from a variety of options including dominoes, dancing, singing, knitting, crafts, model making, ball games, gardening and many more. The activity coordinator told us they kept a six monthly 'preference audit' which helped ensure the activities provided reflected people's individual interests and preferences. We saw they also maintained records, for evaluation purposes, of who had taken part in which activates this too is recorded for their own personal evaluation. The activity coordinator told us they organised a choir with the local church and relatives were invited. There was an activity programme displayed on the notice board in the main entrance. There were also display boards in the lounge, however we saw they did not reflect all the activities on offer.

The care plans, including risk assessments, we looked at followed the activities of daily living such as communication, personal hygiene, continence, moving and mobility, nutrition and hydration and medication. They contained details of their personal history, interests and guidelines for staff regarding how they wanted their personal care and support provided. This helped ensure that people's care and support needs were met in a structured and consistent manner.

The records were generally well maintained and up to date, including details of monthly reviews. Although we saw certain annual reviews required completing.. They also contained details regarding people's health needs, their likes and dislikes and their individual routines. This included preferred times to get up and go to

bed, their spiritual needs and social interests. We saw all individual files contained 'emergency plans' for use should a person be taken to hospital. This demonstrated that the service was responsive to people's individual needs.

Records indicated that comments, compliments and complaints were monitored and acted upon. Complaints were handled and responded to appropriately and any changes and learning implemented and recorded. For example, we saw that, following a concern raised by a relative, a person had their care plan reviewed and their support guidelines amended. Staff told us that, where necessary, they supported people to raise and discuss any concerns they might have. The deputy manager showed us the complaints procedure and told us they welcomed people's views about the service. They said any concerns or complaints would be taken seriously and dealt with quickly and efficiently, ensuring wherever possible a satisfactory outcome for the complainant. This was supported by people using the service and relatives we spoke with who told us they knew what to do if they had any concerns. They also felt confident they would be listened to and their concerns taken seriously and acted upon.

Good

Our findings

People and their relatives spoke positively about the management at the Heights and said they liked the way the service was run. A health care professional we spoke with said they felt significant improvements had been made and they had confidence in the management of the service. Staff were aware of their roles and responsibilities to the people they supported. They spoke to us about the open culture within the service, and said they would have no hesitation in reporting any concerns. Staff told us they felt supported by both the registered manager and deputy manager, who they described as very approachable. They felt able to raise any concerns or issues they had. We saw documentary evidence of staff receiving regular formal supervision and annual appraisals.

The registered manager understood their responsibilities in relation to their registration with the Care Quality Commission (CQC). They had submitted notifications to us, regarding any significant events or incidents, in a timely manner, as they are legally required to do. They were aware of the requirements following the implementation of the Care Act 2014, such as the requirements under the duty of candour. This is where a registered person must act in an open and transparent way in relation to the care and treatment provided. The deputy manager also confirmed they took part in reviews and best interest meetings with the local authority and health care professionals, as necessary.

Arrangements were in place to formally assess, review and monitor the quality of care. These included regular audits of the environment, health and safety, medicines management and care records. We saw these checks had helped the registered manager to focus on aspects of the service and drive through improvements. For example, more concise and comprehensive care records were being developed and implemented. Staff awareness, training and practices were also being improved, through the introduction of the Dementia Care Framework, to enhance their knowledge around the subject of dementia care. This demonstrated a commitment by the management team to develop and enhance the performances of staff and systems, to help drive improvements in service provision.

Care records including care plans and medicines were reviewed periodically and in response to incidents and changes in people's needs. The regional manager described a number of audits carried out by staff, the management team and on behalf of the provider to monitor and assess the quality of service provision. There was also a monthly return covering all aspects of the service completed by the registered manager and submitted to the provider. The regional manager also confirmed the service was subject to monitoring visits from the local authority.

Appropriate policies and procedures were in place for staff regarding the reporting of accidents and incidents. We saw that all such accidents and incidents were recorded and analysed in order to highlight any patterns or themes. The deputy manager explained that where any trends had been identified, measures would be put in place to minimise the risks of any re-occurrence. We found records relating to the provision of care by the service were fit for purpose. They were readily accessible, up to date, legible and accurate. Where appropriate records were stored securely and restricted to those people authorised to see them. This ensured confidentiality of records for people using the service.