East Anglia Care Homes Ltd

Halvergate House

Inspection report

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Ratings

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

Overall summary

This unannounced inspection of Halvergate House was undertaken on 13 October 2014. The last inspection was undertaken on 15 and 16 July 2014 and we found breaches of the regulations during that inspection.

At that inspection we were concerned about inadequate staffing levels. We judged this to be a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) 2010.

Following this inspection the provider sent us an action plan telling us what action they were going to take to improve.

During this inspection we found that the required improvements had not been met. We subsequently found further breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which correspond to breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Halvergate House provides accommodation and support to a maximum of fifty people, some living with dementia and some who also require nursing care. Halvergate House also provides rehabilitation and respite services. There were thirty nine people living in Halvergate House when we carried out our inspection.

Summary of findings

At the time of this inspection the home did not have a registered manager in place. 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 and associated Regulations about how the service is run. The provider was in the process of recruiting a registered manager. There was an interim manager in place who was managing the services on a day to day basis with assistance from the provider's operational manager.

The Care Quality Commission (CQC) is required by law to monitor the operation of the Mental Capacity Act 2005, Deprivation of Liberty Safeguards (DoLS), and to report on what we find. The DoLS are a code of practice to supplement the main Mental Capacity Act 2005 Code of Practice. We found the location to be meeting the requirement of the DoLS.

There were insufficient staff on duty in order to meet people's needs safely and effectively.

People's care and support needs were recorded. However, for some people the information recorded and used by nursing staff did not carry across to care provided by care assistants. For example fluid intake charts and repositioning charts were missing or not completed regularly.

The majority of staff were kind and compassionate, however, people were not always treated with respect and dignity.

Discussions with staff told us they were fully aware of how to raise safeguarding issues.

The provider had a robust, safe and accurate system for ordering, storing and administering medications. Current and relevant professional guidance was followed regarding the management of medicines. Staff had sufficient training to enable them to manage people's medicines safely.

Staff were appropriately trained and skilled. They understood their roles and responsibilities. Nurses had the clinical skills they needed to ensure people's health needs were met. Staff received regular supervision and appraisals. However, some staff told us they did not feel supported by the management team in the home.

We have recommended that the provider look at how it can improve the lives of people living with dementia.

The provider had a quality assurance system and regularly sought the views of people living in the home. Family members, staff and other health and social care providers also took part in surveys.

People knew how to make complaints and staff knew how to respond to complaints.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) 2010, which corresponded to breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

The provider did not ensure that there was always sufficient staff on duty to make sure that practice was safe.

Staff recruitment processes were not robust enough to ensure that only suitable staff were employed at the home.

With the exception of new staff undertaking training, all staff we spoke with knew how to recognise and respond to abuse appropriately.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Whilst people and their families were involved in their care we found shortfalls in communication between nursing staff and care assistants. This impacted on people's continuity of care.

People were not always supported to communicate effectively and some care plans did not reflect accurate or up to date circumstances.

The interim manager had an awareness of the Deprivation of Liberty Safeguards (DOLS). The interim manager had applied for DoLS in people's best interest. Staff also had knowledge of the Mental Capacity Act 2005 and DoLS.

Is the service caring?

Requires Improvement

The service was not consistently caring.

At times staff demonstrated a lack of understanding about the need to engage with people in an appropriate way in order to help them make choices.

People's respect and dignity was not always upheld. Independence was not always encouraged and supported.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People did not always receive personalised care that was responsive to their individual needs. This meant that we could not be sure that people's health, social and emotional needs were being met.

People's relatives told us that they knew how to complain if they needed to and staff knew how to respond to complaints.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

Summary of findings

The majority of staff and people living in the home that we spoke with told us that they thought the management did not listen to concerns about the care and support being provided.

Communication between all staff within the home was somewhat disjointed with clear overtones of 'them and us'.

At the time of the inspection the provider had no registered manager in place.

Halvergate House

Detailed findings

Background to this inspection

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

This inspection took place on 13 October 2014 and was unannounced. Two inspectors carried out this inspection.

Before the inspection we reviewed all of the information we held about the service including information received and notifications. Notifications are events that happen in the home that the provider is required to inform us about by law. We asked the provider to complete and return a provider information return (PIR).This is a form that asks the provider to give some key information about the service, what the service does well and any improvements that they plan to make. We did not receive the completed PIR.

During our inspection we spoke with nine people who used the service, four relatives and fourteen staff members. We looked at the care records and support plans of four people, looked at six people's medication administration records (MAR), management records such as minutes of meetings, accident reports and audit results.

We used the Short Observational Framework for Inspections (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Is the service safe?

Our findings

At our previous inspection on 15 and 16 July 2014 we were concerned about inadequate staffing levels. We judged this to be a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. We issued a compliance action and asked the provider to provide us with an action plan outlining how they proposed to make the service safer. Their action plan told us that they would continue to recruit sufficient staff and that they would review and monitor staffing hours. They told us that this would be completed by 3 September 2014. During this inspection we found that the required improvements had not been made. We found that there was still not enough staff to meet the needs of the people who lived in the home.

We found people living in Halvergate House were not always protected from the risk of avoidable harm. One person living in the home had been identified as being at high risk of falls. Falls risk assessments had not been taking place regularly. This person had fallen and sustained a serious injury. There was no action plan in place to support this person back to independence. Instead this person told us, “I seem to spend all day in bed now. When they do get me up it’s only for a short while and I sometimes refuse to go back to bed, which they don’t like”. They added, “There’s not enough staff to look after me properly”.

This person had also been identified as high risk regarding their skin integrity. This meant that this person should be regularly repositioned to help reduce the risk of pressure ulcers occurring. The only records of this person being repositioned in bed took place between 5 and 29 September 2014. Only one transfer from the bed to a chair was recorded on 29 September 2014. This was despite this person’s care plan stating that two hourly repositioning should take place.

We also looked at this person’s bed rails risk assessments. These assessments are carried out to ensure that vulnerable people are protected from falling out of bed. The only record of such an assessment taking place was dated 14 November 2013. Therefore we could not be assured that regular assessments of this person’s risk relating to bed rails had taken place.

All of the care assistants we spoke with told us that they felt there were not enough staff to adequately meet people's needs. One care assistant said, “People only get attended to when it is possible to do so”. Another staff member told us, “We are constantly running short staffed. I have worked here a long time and seen many, many staff changes, too many in fact”.

One person living in the home that we spoke with told us that they did not think there were enough staff. They told us that they did not feel well cared for. They said that they were often quite, "Fed up". Another person we spoke with said, “I sometimes wait for an hour to be seen to but the staff are very busy”. One person's relative we spoke with said, “The care here is good but there are not enough staff and it’s always difficult to find a care assistant”.

A further person living in the home told us, “Staff get me up early when I don’t want to get up early”. They added, “I get put to bed early too but don’t want to go to bed early”. They thought this was because the day staff had to get everyone to their bedrooms before the night staff started work.

The staffing levels had been assessed by the provider but the interim manager did not know whether a staff planning tool had been used. A staff planning tool helps providers work out how many staff are required to look after a person depending on their personal needs. Staff rotas were prepared four weeks in advance and showed planned staffing levels based on full occupancy. These were two registered nurses and eight care assistants in the mornings; two registered nurses and six care assistants in the afternoons and one night nurse and three care assistants at night-time.

On the day of our inspection two registered nurses and six care assistants were rostered to work the morning shift. This was contrary to the providers own staff planning tool recommendation of eight care assistants for the morning shift. During the morning of our inspection a seventh care assistant was called in to work. The service was therefore not meeting its agreed numbers of care assistants required to be on duty for the morning shift.

The care assistants that we spoke with told us that the eight care assistants on duty on the morning shift should be: three upstairs and two downstairs in the old part of the building and that the remaining three care assistants covered the newer part of the building, the Tunstall unit.

The service was one care assistant short on the morning shift of the inspection. We spoke to staff in the upstairs part of the old building as this was where the staff shortage was.

Is the service safe?

They told us that if the required number of care assistants were on duty (three) then they would finish getting people up and out of bed between 11.30am and 12 noon. They said that when there were only two care assistants on duty (as there were on the day of our inspection) then it would be at least 12.30pm before they assisted the last person to get up. They said, "We just scrape it in time for lunch." They went on to say that this meant some people had a late breakfast shortly followed by their lunch. We observed that one person was still in bed at 11.20am. Their breakfast was still on the bedside table. We saw that at 11.50am two care assistants attended to this person's personal needs. Shortly afterwards, at 12.13pm, this person was assisted downstairs for lunch.

We then looked at the staff rosters for the five weeks prior to the date of our inspection and noted that each week there were significant shortfalls in the number of care assistants on duty predominantly during the day. The service's permanent staff covered a lot of the shortfalls and worked extra shifts. This included working early and night shifts on the same day. The provider was in the process of phasing out long day shifts and providing staff with shorter more structured hours. They believed this would enable more staff availability at key points of the day, for example at mealtimes in order to assist residents to eat.

We judged the above to be a continuing breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The majority of staff we spoke with understood what safeguarding was. They said that they had received safeguarding training and that this was mandatory. They could tell us about the different types of abuse and what they would do if they suspected abuse was happening. They knew where to locate the provider's safeguarding policy and procedures. We asked new members of staff whether they had received training in relation to safeguarding. Neither person had received the training but knew what we meant.

The majority of the people we spoke with who used the service told us that they felt safe. One person told us, "I do feel safe here and have a good relationship with most of the staff".

Standards of cleanliness and hygiene in the home were acceptable. One relative we spoke with said, "The home is always spotlessly clean with no bad odours".

We looked at the process for staff recruitment. We found that previous employment checks had been made and that staff had undertaken a Disclosure and Barring Service check. There were staff files where the required information was not seen on the day of inspection but this was subsequently clarified by the provider.

Medicines were stored, administered and audited safely and correctly. Only registered nurses administered people's medicines. People received their medication on time and there were procedures in place for "as required" (PRN) medicines and "homely remedies". People told us that if they requested any PRN medicines, such as painkillers, then these would be given in a timely manner. We saw that the procedure for medicines errors had been followed. This included refresher training for staff if needed.

Is the service effective?

Our findings

One person's relative told us, "[family member] always gets a choice at mealtime. The soft diet is provided because [family member] has problems swallowing". We looked at this person's care plan. It stated that they required a soft diet and thickened drinks. The care plan also stated that they needed staff supervision when eating or drinking due to risk of choking. At the lunchtime meal we observed this person. They struggled to swallow their food at the beginning of the meal and started to cough. They were then taken back to their room without further offer of support to eat their meal. We saw that they had a drink in their room but there was no staff supervision to drink it. The person's care plan stated that staff were to encourage them to drink at least 2 litres of fluid a day. The person did not have a fluid intake chart to support this. This meant the staff could not be sure how much fluid the person had drunk each day.

One person we spoke with living in the home told us, "They make me drinks but don't think about how I am going to manage picking them up and drinking them". No fluid intake was recorded in this person's daily care record, only the number of 'sips' taken. We discussed with the interim manager ways of ensuring this person received adequate and accessible drinks. However, a family member has since reported back to us that whilst things improved for a while, they are now back to 'normal', i.e. stale drinks or drinks that cannot be reached. They reinforced their concern that a lack of fluids was contributing to their family member's headaches.

Nationally recognised screening tools were used to determine people's risks. These included risk of malnutrition or obesity and people at risk of developing pressure ulcers. People at risk of developing pressure ulcers had pressure relieving mattresses in place. However, we did not see turning or repositioning charts for people at risk of pressure ulcers. We did not see any food or fluid intake charts for people at risk of malnutrition. We asked staff about food and fluid charts. Some said they had seen some being used but not many. One staff member said charts would be in the nursing notes. However we checked the nursing notes of one person living in the home that was at risk of pressure ulcer and found no food or fluid charts recorded for them.

We noted that one person was identified as being at low risk of malnutrition. This was despite them requiring supervision to eat and drink and having swallowing problems. Another person's care records indicated that they were losing weight. Weight was recorded for July and August 2014 but nothing had been recorded for September and October 2014. There was dietician intervention but the last recorded intervention was dated 16 June 2014.

We noted that in the Tunstall unit people were not always adequately supported to have a sufficient, balanced diet. The staff asked people if they were finished eating. Two people said yes. Their plates were removed and they were immediately given their pudding without first asking if they wanted their pudding. Another person was asked if they had finished their main course but the care assistant did not wait for a reply. They removed the person's plate and gave them their pudding.

Staff did not document what people had eaten. This meant staff could not be assured people had eaten and drunk sufficient quantities. One person told us that they did not enjoy their lunch and said, "This mince is awful". They left their lunch and were not offered an alternative. Instead they were given their pudding. They attempted to eat this but struggled. Whilst people were offered choice about what to eat and drink they were not always supported appropriately during mealtimes.

People had mixed views about the food at Halvergate House. One person we spoke with said, "The food isn't very good". Another person said, "The food is very good". Staff told us that people had a choice of two dishes over lunchtime and that there was always an additional vegetarian dish. All of the staff we spoke with said that mealtimes were particularly "challenging" because people's nutritional needs could not be met in a timely manner.

These failings were breaches of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People had regular access to health professionals for advice and treatment for their specific needs. This included dietician advice, GP visits and speech and language therapy.

Is the service effective?

People's care plans stated that staff must ask people for their consent before delivering any personal care. All of the staff we spoke with understood the term 'consent' and what it meant. People's care plans we looked at showed that they had given consent to the care and treatment that they had received. With the exception of one care plan relatives had signed to agree their consent.

During our inspection we did not always see the staff obtain people's consent before they delivered any care or support. This included placing clothes protectors around people at mealtimes without asking their permission beforehand. Another member of staff moved people in their wheelchairs to the dining areas without informing people where they were going beforehand.

All of the staff we spoke with had a good understanding about mental capacity. They told us that they had received training in relation to this. This was confirmed by looking at the provider's training records.

We discussed the Mental Capacity Act 2005 with the interim manager. They were able to demonstrate a good understanding of the Act and went on to tell us about Deprivation of Liberty Safeguards. One person was going through the application process at the time of the inspection. Staff were able to outline to us what 'best interest' decisions were and told us about judging whether a person had capacity to understand and make decisions for themselves. We saw from care plans that people's mental capacity was assessed on admission and as part of regular reviews.

Staff told us that they had completed their training and could access further training if required. They told us that they received regular supervision and were given the opportunity to give their views during those sessions. They said that they received annual appraisals. Some staff told us that they had raised staffing concerns through various meetings or supervision sessions but that staffing levels continued to be a problem for them.

Two of the staff we spoke with had recently commenced employment. They told us about the induction training that they had received. They said that there had been two classroom days and they had shadowed more experienced staff. They told us that they had also been given an 'induction manual' to complete.

Requires Improvement

Is the service caring?

Our findings

One person we spoke with said, "Some of the staff are kind but not all of them". Another person said, "The staff are nice. There are one or two that are a bit, well you know, a bit short with you sometimes". The third person said, "I'm okay and have no complaints. Staff are nice, well, most of the time. They are too busy all of the time though".

During the afternoon of the inspection we observed one person sitting in a wheelchair in the foyer area. The person said, "I have been sitting here for a long time. I want to go home". This person had wanted to use the toilet. During this time we observed two staff walk past the person. They did not ask if they were all right or needed anything. We found a registered nurse who asked a care assistant to assist the person. We saw the care assistant tutted and pulled their face. They said to the person, "You have only just been".

People were told what was happening and where they were going rather than being asked if they would like to do something or go somewhere. For example, people were wheeled to the toilet without staff always asking them whether they required the toilet.

People's dignity was not respected and promoted during mealtimes. Staff who assisted people to eat their meals did not always behave in a respectful manner to them. For example, we observed staff saying, "open wide" and "good girl".

The provider undertook pre-admission assessments which helped them meet people's individual needs. However, in one person's care plan we looked at we noted that their personal history had not been reviewed since admission. Therefore there were no on-going discussions recorded with this person about what was important to them, what their preferences might be, had their likes and dislikes changed and was the provider doing all it could to ensure this person was happy living at Halvergate House.

We judged the above to be a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The majority of people we spoke with told us that they felt the staff were kind and caring. One person said, "The staff are very kind". Another person said, "The staff are lovely".

People living in the home told us that they thought they knew what was in their care plans but could not remember being involved in the writing of them. They said that they felt the care and support they received reflected their needs. People's relatives that we spoke with told us that they were involved in the planning of care for their family member.

Requires Improvement

Is the service responsive?

Our findings

People were not always supported to enable effective communication. For example, one person's care plan stated that an alphabet board should be used to communicate. This is a board which contains a grid of letters and numbers to which an individual points to communicate. We asked the person and their relatives whether the alphabet board was used and they said no. The person's care plan stated, "It is very hard to communicate as [person] does not verbalise. The same care plan later stated, “[Person] does verbalise if you speak clearly and give them time to respond”. This statement contradicted itself. We later spoke with the person concerned and found that they could verbalise.

We looked at how the home provided activities and supported people’s interests. We found one person's care plan stated that they went to the lounge to join in with the activities in the afternoons. This person told us that they did not join in with the activities and preferred to spend time on their own. We reviewed the activities records for this person. There were numerous gaps in the records. Many days did not have anything documented. This meant that the care plan contradicted the activities register. We were therefore unable to establish whether this person received activities specific to their personal needs. We asked a family member about this person’s activities. They told us, “[person using the service] doesn’t mix much. Sometimes they get taken out into the garden which they enjoy, but otherwise nothing much happens”.

Risk assessments were in place although some reviews were missing. This meant that we could not be sure that people received regular reviews which monitored and addressed their changing needs.

Most people’s personal histories were documented in their care plans. These included their hobbies and interests.

However, one person's personal history had very little document. The information was not person centred and did not include what the person enjoyed doing. Another person had no personal history recorded at all.

We spoke with the activities coordinator. An activity had been scheduled for each afternoon with the exception of Sundays. Scheduling included bingo, quizzes and gentle exercises. They told us that they assisted some people with their personal care as the service was particularly short-staffed.

Whilst regular activities took place we found that there was a lack of effective stimulation for people living with dementia. For example, we did not see reminiscence activities scheduled. Neither did we see items or articles from the past to encourage discussions about things which were important to people. This meant that some people were not enabled to receive person centred care.

We found four people’s care records did not have reviews recorded since July and August 2014. This meant that we could not be sure that these people received continuity of care. Neither could we be sure that their individual needs were being assessed appropriately.

We recommend that the service seek advice and guidance from a reputable source, about the management of people living with dementia in particular their environment and activities.

We observed the handover between the early and late staff. It was evident that staff knew the needs of people. The staff we spoke with told us that any changes in people's needs were stated during the handover periods. This helped to ensure the continuity of people's care.

People's relatives told us that they knew how to complain if they needed to. They told us that they were satisfied with the outcomes of their complaints. One relative said, "I feel that I can complain if I need to. I have previously complained to the manager and things were sorted out quickly".

Is the service well-led?

Our findings

At the time of this inspection there was no registered manager in place. The provider was actively recruiting and there was an interim manager in place supported by the provider's operational manager.

One person living in the home told us that they thought the provider could be a little more interested in the people living there. They added that they saw how difficult it was for the care assistants at times, with little support coming from management.

One care assistant told us how they thought poor communication within the home was a big problem. They added that if the nurses shared information with the care assistants about people then they believed things would improve.

None of the care assistants we spoke with told us that they were encouraged to participate in quality initiatives. They all said that they felt their job was to provide personal care to people and nothing more. Care assistants told us that generally they did not feel valued. This impacted negatively on the culture and relationships between staff in the home.

Four care assistants we spoke with told us that they had not had a break during their shift on the day of our inspection. They said this was because there was not enough staff on duty. We asked management what happened when people could not take their scheduled breaks. We were told that staff were encouraged to take their breaks regularly and that if necessary staff were pulled from other areas of the home to cover break periods. We did not see this happen for the four staff members we spoke with.

Staff, relatives and resident meetings took place. However, some care assistants told us that although staff meetings took place they were not always given the minutes to read. This meant that they were not kept up to date with recommendations or changes. Registered nurses told us about meetings and feedback. They said they felt more supported by the management team than by the care assistants. Regular surveys and quality questionnaires took place and the provider was in the process of issuing the 2014 quality survey at the time of the inspection.

The interim manager continued to carry out audits although the recording of audit results did not take place in a timely manner. Audit results for medication, care plans and pressure ulcer care for August and September 2014 were not entered up which meant that results could not be analysed and acted on. This meant that people's health and welfare may have been compromised. We discussed this with the interim manager who agreed to update the audit records as a priority.

These issues represented breaches of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Registered nurses told us that they felt empowered to undertake quality initiatives. These initiatives focused on improving quality in specific areas of care. For example, one registered nurse was responsible for medicines quality within the home. We saw that the regular ordering storing and administration of medicines was enhanced by the additional focus on medicines quality.

The interim manager and operational manager had informed the CQC of significant events in a timely way, as required by law. This meant we could check that appropriate action had been taken.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing **Sufficient numbers of suitable staff were not deployed in order to ensure people's needs were met. Regulation 18(1)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs **The nutritional and hydration needs of people were not always met. Regulation 14(1)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect **People were not always treated with dignity and respect. Regulation 10(1)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Systems and process were not in place to effectively monitor risks and the quality of service provided to continually evaluate and improve the service. The views of staff were not routinely sought to help improve the service. Regulation 17(1)(2)(a)(b)(e)(f)**