Alexis Care Limited

Heanton

Inspection report

Heanton Punchardon
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Devon
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Tel: 01271813744

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Ratings

Overall rating for this service	Inspected but not rated

Is the service safe?	**Inadequate**
Is the service effective?	**Requires Improvement**

Summary of findings

Overall summary

Heanton is nursing home registered to provide accommodation for up to 58 people who require nursing or personal care. It specialises in the care of people living with dementia. The home has two units, known as Williamson and Chichester.

In October 2014 we carried out an unannounced comprehensive inspection, where we judged the service to be overall good, but required improvement in the responsive domain. . After that inspection we received concerns in relation to risks not always being managed effectively. These included concerns there were not enough care staff to meet the needs of the people living at the home and that essential safety works had not been completed. Initially we sought assurances from the registered manager and provider. However during September 2015, we received a number of concerns about lack of staff. As a result we undertook a focused inspection to look at those concerns on 15 October 2015. We also looked to see that some essential safety work at the home had been undertaken. We found the two domains we inspected, safe and effective care required improvement. In particular, we found there was a shortage of staff to meet people's needs. The provider was addressing this with recruitment and was supporting staff to enhance their skills through training to meet people's needs. Essential works had been undertaken or had set timescales to be completed.

On 22 December 2015, we carried out another focused inspection. This was in response to some safeguarding information, which included two people developing pressure sores, whilst living at the home. There were also concerns about medical assistance not being sought for people in a timely way. We also received concerns from two relatives about low staffing levels and poor care being delivered. At the time of the inspection there were 50 people living at the service, although two people were in hospital.

Since our last inspection the registered manager had resigned and left. A new manager was in post who was undergoing the process to register with Care Quality Commission (CQC). 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 2014 and associated Regulations about how the service is run.

This report only covers our findings in relation to these topics. You can read the report from the last comprehensive inspection by selecting the 'all reports' link for Heanton on our website at www.cqc.org.uk

People were not always safe because there were not enough staff on duty at all times to meet the needs of people in a timely way. This was because of staff sickness, staff resigning and some newly recruited staff deciding not to follow up on employment. On the day of the inspection there were six care staff plus one nurse working on one of the units and five care staff plus one nurse on the other unit. Staff said this was unusual and they had been operating in the recent weeks with only three or four care staff and one nurse per unit. This was supported by relatives we spoke with during this inspection. One said ''The staff are very

good, there is just not enough of them.'' One family reported their relative had been found still in bed in their night attire at 11.30 am in the previous few weeks and only just having their breakfast. When the relative asked why this had occurred, the staff said they were short staffed and could not get everyone up at a reasonable time. Another relative said their relative had got outside at night where a door had been left open by staff. They said their relative was ''At risk of harm to themselves as there was not enough staff to support and supervise people.'' We saw there was an incident form in relation to this event, but no signage had been put on the fire door.

The manager said the service had been working with four care staff and a nurse on each unit but ideally needed five staff and a nurse to meet the needs of people. Staff staffing rotas from the previous two weeks showed there was a nurse and four care staff on each unit during the day. However, on three occasions there were only three care staff on duty in a unit. Staff said low staffing levels meant people did not receive their care in a timely way and there were more accidents and episodes of physical and verbal aggression towards people and staff, when staff couldn't supervise or spend time with people. This increased risks for people and staff.

When we fed this back to the managers and provider, they agreed staffing retention had been an issue and they were looking at ways they could ensure there was sufficient staff to cover the next two weeks, whilst new staff were being recruited and inducted. This included asking current staff if they wished to do overtime shifts, checking with other homes owned by the same company whether there were staff who could provide cover and using agency staff. They had already sent requests to local agencies for shifts that needed to be covered.

There were risks to people's health in relation to the adequacy of the management of skin care . Two people had developed serious pressure sores at the service (known as grade 3 or 4). One person's pressure ulcer had required hospital admission for treatment. We also found one person who was high risk of developing pressure sores did not have a risk assessment in place to show how their risks had been assessed. Where people had been assessed as at risk of developing pressure ulcers, we found pressure relieving equipment was in place such as airwave mattresses, although care plans did not always indicate what setting these should be set on for the person's weight. Where people needed regular changes of position to reduce the risks of them developing pressure sores, records of changes of position was not recorded in a timely way and there were some gaps in these records. These meant risks of developing skin damage were increased for people.

There were a number of new staff at the service who were undergoing training and induction. New staff said they felt well supported by existing staff and were receiving training appropriate for their role. Several staff who had worked at the service for longer said they would like more practical training particularly on meeting the needs of people living with dementia and on managing behaviours that challenged the service. Staff also said they needed more equipment, particular hoists, slings and stand aids, which are used for moving and handling people. When we discussed this with the provider, they explained some equipment was awaiting repair parts and that a new hoist had been ordered and would arrive soon.

There were two breaches of regulation found at this inspection. You can see what action we told the provider to take at the back of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People were at risk because there were times when staffing levels fell below what the provider had assessed was needed to keep people safe and meet their needs.

Risk assessments were not always in place for pressure care or did not include all the relevant information, which put people at increased risk.

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

Is the service effective?

Requires Improvement

Some aspects of service were not effective.

People were supported by staff who were trained and supported to meet their health care needs, but some staff said they needed more specific training.

People were not always supported to access healthcare services to meet their needs in a timely way.

Most people were given support to eat and drink. Where people were at increased risk of malnutrition or dehydration, staff were aware of this and made sure they food and drink regularly and nutritional supplements, when needed.

Heanton

Detailed findings

Background to this inspection

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

We undertook an unannounced focussed inspection of Heanton on 22 December 2015. We had received concerns about staffing levels and risks to people not being managed well. This included pressure care and managing behaviour which may challenge the service. The inspection was completed by two inspectors over one day. The team inspected the service against two of the five key questions we ask about services: is the service safe and is the service effective?

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

During our visit we met with five people to gain their views about the care and support they received. Not everyone was able to verbally share with us their experiences of life at the home. This was because of their dementia/complex needs. We therefore used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We also spoke with seven visiting relatives. We met with 13 care staff, and the manager, director and lead on dementia care, dementia care specialist advisor, training coordinator for the company and spoke via a video link to the provider. We looked at 10 people's care records which included risk assessments, care plans and at staffing rotas over a four week period.

Following the inspection we spoke with one health care professional.

Inadequate

Is the service safe?

Our findings

We had received notifications from the service which highlighted two people had developed serious pressure sores (known as grade 3 or 4). The senior managers who investigated the circumstances of this found poor practice and inadequate record keeping in respect of how those people's pressure care was being monitored and reviewed. There were gaps in the records of how often people were being turned to relieve their pressure areas and in care records about how they were being monitored. One person was found to have a dressing on their toe, with no documentation of who or when had first applied the dressing.

We looked at the care of another person who was in bed and needed repositioning every hour. At night, staff were recording their care on a chart in the person's room, but during the day staff were recording this on the computer. Several staff were visiting the person during the day to check on them, offer care and repositioning. However, when we asked when the person was last repositioned, the staff member wasn't sure. This was because the computer records had not yet been updated by care staff. These arrangements increased the risk the person might not receive their care at the right intervals.

We found one person who was at risk of pressure damage had a pressure relieving mattress. However, they did not have a care plan or risk assessment such as a Waterlow, to show how their risks had been assessed, reviewed or what action had been taken to reduce those risks. We reviewed seven risk assessments in relation to pressure care and found only one gave clear instructions in respect to what setting the airwave mattress should be set at for the person's weight..

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

We spoke with a nurse about this who explained that named nursing staff were responsible for setting the pressure relieving equipment to the correct setting for each person's weight. In communal areas we observed people who needed pressure relieving cushions were sitting on them.

In light of the two pressure sores acquired at the home, the senior management team had worked with the GP to review each person's people's skin and completed body maps (which showed the location of any skin damage). They had developed an action plan for each person highlighting any improvements needed in care records in relation to skin damage risks. They also planned to work with staff to develop and improve care plans to show how risks of pressure damage would be assessed and monitored. During our visit, a nurse had updated several of the records highlighted in the action plan and was working on completing others.

Other actions included ensuring people at high risk had time to rest in bed each day to reduce pressure on areas more prone to skin damage, such as buttocks. We observed staff discussing who needed bed rest during the afternoon of our visit. Several staff mentioned this task was often impeded because of lack of equipment as they only had one working stand aid and one working hoist. This meant this equipment needed to be shared between two floors, and sometimes people had to wait for it to be sent in the lift. When

we fed this back to the provider, they assured us a further hoist had been ordered, as they had encountered difficulties in getting parts for two hoists which needed repair.
We had received information via safeguarding alerts and complaints from families that there continued to be a shortage of staff to meet people's needs safely and in a timely way. On the day of the inspection, there were six care staff plus one nurse and one activities coordinator on the ground floor unit and five care staff, one nurse and an activities coordinator on the top floor unit. Staff said this was unusual to have this level of staffing, and that it was usually less than this.

Ten staff reported they had worked in the past weeks with only three care staff and one nurse per unit. One care staff said, "It's been horrendous", another said, "The main problem is lack of staff." Staff described the ways in which low staffing levels impacted on people's care. This included not being able to deliver care in a timely way, not being able to spend time with people. Staff also described how a lack of staff supervision in communal areas increased the risk of falls, and of outbursts of verbal and physical aggression between people, if a staff member was not nearby to intervene. Relatives we spoke with confirmed they thought the home was short staffed. One said, ''The staff are very good, there is just not enough of them.'' Another relative said the recent changes in staff meant a lot of new staff didn't really know the person of how to care for them. One family reported their relative was found still in bed in their night attire at 11.30 am and was only just having their breakfast. When asked why this had occurred the staff said they were short staffed and could not get everyone up at a reasonable time. A relative said their relative had got outside at night where a door had been left open by staff. They felt their relative was at ''Risk of harm to themselves as there was not enough staff to support and supervise people.''

We looked at rotas over a four week period, two weeks previous to the inspection and for the next two weeks. Staff staffing rotas from the previous two weeks showed there was a nurse and four care staff on each unit during the day most of the time, although the manager said a nurse and five care staff were needed. However, on three occasions there were only three care staff on duty in one unit. The rotas showed there were a number of vacant posts and lots of staff sickness. The rotas for the next two weeks showed there were still a number of gaps in recommended staffing levels which staff were trying to find cover for.

The senior management team agreed staffing retention had been an issue and they were looking at ways they could ensure there was sufficient staff to cover the next two weeks, whilst new staff were being recruited and undergoing induction. This included asking current staff if they wished to do overtime shifts, checking with other homes owned by the same company whether there were staff who could provide cover and using agency staff. They had already sent shifts needing cover to local agencies for requests for cover.

We concluded the staff shortages were due to staff sickness, staff retention and new staff choosing not to continue working at the home beyond their induction period. . Staff had been struggling to meet people's needs and keep them safe, which had adversely affected their care.

This is a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There had been three safeguarding alerts in the earlier part of the year, one in October 2015 where a person had sustained a significant injury following a fall. The nursing staff on duty at the time did not seek medical assistance as they did not feel the person was showing symptoms of having a serious injury. Since this incident, the previous registered manager had asked all nursing staff to ensure medical advice was sought either via a GP visit or to the accident and emergency department following any significant fall of a vulnerable person.

Just prior to this inspection there were a further incident where a nurse had not sought medical input for one person who had been pushed by another person and sustained an injury to their arm. The reports showed that during the night the nurse noted significant swelling and bruising, plus leakage to the persons arm, but emergency medical help was not sought until the morning. During the inspection we noted one person had severe bruising and cuts to the face and head. We checked their care records and talked with staff about how they sustained such a significant injury. One staff member told us the nurse on duty had been reluctant to call the emergency medical team. They claimed they had to insist on this course of action and there had been a need for them to speak to senior staff about the lack of action being taken by the nurse . We fed this back to the provider and senior management team and asked for this to be investigated.

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

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

Accidents and incidents were reported and were recorded on an electronic database. We looked at several incidents reported over the past few days. We saw the manager reviewed each incident and tried to identify further measures to reduce risks. Data about accidents and incidents were available for each person and for service, so the manager and provider could monitor any emerging themes or trends about accidents and incidents. This meant they were prompted to take further action to reduce risks when needed.

The registered provider and manager said the service was planning to introduce a new dementia care model to improve the quality of care. The service would be divided up into different houses, each providing for the specific needs of people with dementia, depending on their level of dementia and the type of support they needed. Staff would be matched to the different houses and shift patterns were being changed to ensure better cover across the whole week. Some staff said they had found the staff rota changes had not helped staff morale or team working. Others felt it was working well. We heard from the provider how they had gone through a period of consultation with staff and had meetings to explain how their new model of care was being implemented. The provider told us they had employed key specialists to assist them in implementing the new model of dementia care across all their homes in line with current best practice. We were told that at Heanton, this process had been halted due to staffing issues and ensuring staff understood meeting basic care needs. We were informed the new model would not be implemented in full until there were sufficient staff available, with the right skills and training.

Requires Improvement

Is the service effective?

Our findings

A number of people who lived at Heanton sometimes experienced behaviours that challenged the service, related to their dementia. This included episodes of verbal and physical aggression towards staff and other people. This meant staff needed to be vigilant and use their skills to prevent escalation of these behaviours to reduce risks for others and staff.

We looked at the care of three people whose behaviours were challenging to the service at times. We observed a couple of incidents in the corridor and lounge areas but staff nearby intervened quickly to reduce risks for people. Staff on duty demonstrated variable levels of skill, knowledge and experience in managing people with behaviours that challenged the service. Some staff knew 'triggers' for people's individual behaviours and what approach to take to distract the person and de-escalate any aggression, whereas other staff were less confident. Staff said some people were very resistant to personal care and described the various strategies they used to try and gain their co-operation. However, at times, staff said some people needed up to three staff to provide personal care in their best interest. We looked at three people's care plans which provided a good overview of the types of behaviour and any triggers. Staff also told us about the prescribed medicines they used for some people, to manage their mood, when needed. However, care records lacked enough detail about how staff should manage a person when they were refusing care. Most staff said they felt said they needed more practical training on managing people living with dementia and dealing with verbal and physical aggression.

We spoke with two new staff who recently started working at the service. They said they had undertaken training in preparation for the role and worked alongside more experienced staff to get to know people and about their needs. They undertook practical training such as moving and handling and were taught how to use the equipment provided. Both staff said they felt well supported by staff and the manager. They were completing the national care certificate and planned to undertake a qualification in care.

Staff confirmed there was lots of theory based training but they felt they needed more practical training. This included practical training such as caring for people living with dementia, fire drills and moving and handling. We discussed this with the management team who said their current focus was on making sure staff had the basic skills to provide people's day to day care. This was being achieved by working with staff on the floor such as teaching them moving and handling, managing medicines, how to interact with people and through individual and group supervision. Training on pressure area care was planned for January and further training was being planned.

The provider had recently introduced an electronic care record system at the service which staff were being trained and supported to use. Staff reported varying levels of skills and confidence in using the new system, some were very enthusiastic and others were less confident. We saw staff being taught and encouraged to use the system to record daily information about each person. A detailed manual had been given to each member of staff to assist them.

Records showed people had access to healthcare specialists when needed. This included regular visits by

GP's, mental health specialists and a variety of therapists. One relative confirmed their relative's health was being monitored but were concerned the service had not acted on the fact their relative had managed to get outside and fall when a staff member left the door open. They had been given assurances there would be a notice put up to remind staff to keep this door locked but this had not happened. They said the service being offered was not effective and was not meeting their relative's needs and they were therefore seeking to move their relative to another home. We checked the incident form which showed the person had been able to exit the building, but did not come to any significant harm. We checked the door and saw no signage had been put up to remind staff to keep it closed.

People were supported to eat and drink in a relaxed and unhurried way. Our observations showed people had positive experiences and interactions at mealtimes. Throughout the day, people were offered regular food and drink, including snacks and nutritional supplements for people at high risk of malnutrition.

The management team told us about the recent focus on improving people's support with nutrition and hydration and the introduction of nutrition/hydration 'champions.' We spoke with a nurse who was carrying out this role. They explained how they had reviewed each person's nutrition/hydration needs, discussed these with staff and updated their risk assessments and care plans. Several people had been referred to the dietician for advice. They had also discussed people's food likes and dislikes with kitchen staff and arranged for a variety of foods and snacks to be made available so people could be offered food at any time. Each day they discussed people's needs with staff and there was a list in each unit which showed how often food and drink was offered. For people at high risk, food and fluid charts were completed each day.

These changes had a positive impact on people's nutrition and hydration. We found food and drink records were more comprehensive than when we reviewed these during the October inspection, staff were aware of the people at risk and several people had started to gain weight. Some people's health had improved and they no longer needed to be so closely monitored.

The management team described how they were adopting a similar approach to improving pressure area care for people, in order to improve staff practice and further reduce risks for people as quickly as possible.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures	Regulation 18 HSCA RA Regulations 2014 Staffing There were not always sufficient staff to meet the needs of service users.