Bracknell Forest Borough Council

Heathlands Residential Home

Inspection report

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Ratings

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

Overall summary

This inspection took place on 18 and 20 August 2015 and was unannounced.

We last inspected the service on 20 August 2013. At that inspection we found the service was compliant with all essential standards we inspected.

Heathlands Residential Home is a care home without nursing that provides a service to up to 41 older people, some of whom may be living with dementia. At the time of our inspection there were 16 people living at the home and three people staying there on respite care.

The service has been without a registered manager since April 2015. A new manager was employed and is currently

Summary of findings

going through the process to become registered with the Care Quality Commission (CQC). A registered manager is a person who has registered with the CQC 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. The new manager was present and assisted us during this inspection.

People felt safe living at the home and were protected from abuse. They were protected against environmental risks to their safety and welfare and furniture and fixtures were of good quality and well maintained.

People were treated with respect and their privacy and dignity was promoted. Staff were caring and put the needs of people living at the service at the centre of their work. Staff sought people's consent before working with them and encouraged and supported their independence where possible.

People were protected by robust recruitment processes and medicines were stored and handled safely. People told us staff were available when they needed them and that staff knew what they were doing. Staff were well trained and available in enough numbers to meet the needs and wishes of people living at the home.

People told us they enjoyed the meals and confirmed they were given choices. People were supported to maintain relationships with their family and friends and had access to different activities and local community outings.

Over the past 15 months the service had seen a number of changes and many improvements had been made to the service provided. Staff were enthusiastic about the changes and felt the changes made were for the better. Staff were happy working at the service and told us they were a close team that worked well together. The manager oversaw and managed practice at the service and encouraged an open and inclusive culture.

We found one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The service did not maintain accurate and up to date risk assessments and plans of care in respect of each person living at the home. You can see what action we told the provider to take at the back of the full version of this 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 always safe. The service did not maintain accurate and up to date risk assessments and plans of care in respect of each person living at the home.

People were protected from the risks of abuse. Robust recruitment processes were in place to make sure, as far as possible, that people were protected from staff being employed who were not suitable.

There were sufficient numbers of staff and medicines were stored and handled correctly.

Is the service effective?

Good

The service was effective. People benefitted from a staff team that was well trained and supervised. Staff had the skills and support needed to deliver care to a high standard.

Staff promoted people's rights to consent to their care and their rights to make their own decisions. The staff had a good understanding of their responsibilities under the Mental Capacity Act 2005. The manager was aware of the requirements under the Deprivation of Liberty Safeguards and applications had been made as required when applicable.

People were provided with a nutritious diet and staff made sure actions were taken to meet their health and social care needs.

Is the service caring?

Good

The service was caring. People benefitted from a staff team that was caring and respectful.

People's dignity and privacy were respected and staff encouraged people to live as full a life as possible.

Is the service responsive?

Good

The service was responsive. People received care and support that was personalised to meet their individual needs.

People led an active daily life, based on their known likes and preferences. The service was responsive and proactive in recognising the need for improvements and making those improvements with minimal disruption to the people living at the service.

People knew how to raise concerns. Complaints were dealt with quickly and resolutions were recorded along with actions taken.

Summary of findings

Is the service well-led?

Good

The service was well led. People were relaxed and happy and there was an open and inclusive atmosphere at the service.

Staff were happy working at the service and there was a good team spirit.

Staff felt supported by the management and felt the training and support they received helped them to do their job well.

Heathlands Residential 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 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 18 and 20 August 2015 and was unannounced. The inspection team for the first day comprised of one inspector 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. One inspector carried out the second day of the inspection.

Before the inspection the provider completed 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 improvements they plan to make. We looked at the PIR and at all the information we had collected about the service. This included previous inspection reports and notifications the service had sent us. A notification is information about important events which the service is required to tell us about by law.

During the inspection we spoke with seven people who use the service and two visiting relatives. We spoke with the manager, six care workers and two residential care officers. Additional information was provided by catering staff, housekeeping staff and the maintenance person. We observed interactions between people who use the service and staff during the two days of our inspection. We spent time on both days observing lunch in the dining room. Following the inspection we received feedback from an independent mental capacity advocate and two health professionals.

We looked at four people's care plans and medication records, three staff recruitment files, staff training records and the staff training log. Medicines administration, storage and handling was checked. We reviewed a number of documents relating to the management of the service. For example, utility safety certificates, legionella risk assessment, hot water temperature checks, food safety checks and the complaints and incidents records.

Requires improvement

Is the service safe?

Our findings

People were not always protected from risks associated with their health and care provision.

Care plans we saw were out of date and new risks had not been added to them. For example, one person's care plan had been written in December 2014 and said the person had a good appetite. However, the person's daily records and monthly weights showed they were losing weight and their appetite was no longer good. This new risk had not been added to their care plan. Earlier in the year staff had contacted the GP and a nutritional supplement drink had been prescribed twice a day. However, the person had continued to lose weight. We could find no record that the GP had been consulted regarding the continued weight loss. The manager thought the GP had been contacted but that staff had not recorded the contact. On investigation, the manager found that no staff had made the call. In addition, the increased loss of weight and reduced activity meant the person was at an increased risk of skin breakdown. However, no skin integrity risk assessment had been carried out and district nurses had not been consulted on the possible need to introduce measures to prevent skin breakdown.

In another person's care plan dated December 2014, it stated the person was on bed rest. However, staff told us the person had been getting out of bed and going to the lounge every day since approximately four weeks after the care plan had been written. Their care plan had not been updated. The person's care plan of the same date stated the person's skin integrity was good. However, their contact sheets showed the person had a wound that was being dressed weekly by district nurses at that time. The person had been prescribed creams to be applied to their skin four times a day. The daily contact sheet showed this had not been done and there was no care plan or risk assessment for the actual or potential risk of skin breakdown.

We saw other people had pressure mats used by their beds at night. The mats were used with people who were at risk of falls and alerted staff at night that they should go to assist the person who had got out of bed. However, no risk assessments had been carried out on those people's risks of falls and the identified risk had not been added to their care plans. Regular staff knew where the mats were in use. However, without a supporting care plan telling staff what to do to minimise the risk of falls, there was a risk new staff and/or agency staff would not discover this information.

The service routinely completed risk assessments for all people to identify potential risk of malnutrition. However, routine risk assessments for the early identification of the risk of skin breakdown or falls were not carried out.

The service did not maintain accurate and up to date risk assessments and plans of care in respect of each person living at the home. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager contacted appropriate health professionals on the day of our inspection regarding the issues we had identified for individual people.

People were protected from the risks of abuse. Staff knew how to recognise the signs of abuse. They knew what actions to take if they felt people were at risk and were aware of the local authority safeguarding procedure. All staff told us they would report to their manager, in line with the provider's policy, and were confident safeguarding concerns would be taken seriously by the management.

Staff were aware of the provider's whistle blowing procedure and who to talk with if they had concerns. All said they would be comfortable to report concerns and felt they would be supported by the management. People felt safe living at the service. One person told us they felt safe and added: "It is a place to live, we are never harassed." Another person said they felt safe and: "there is someone around 24 hours."

Accidents and incidents were reported internally to the manager. The manager then sent internal incident reports to the provider's health and safety team, who assessed and instigated investigations if needed. We saw some notes the manager had made regarding a recent incident where someone had fallen out of bed. However, although the manager had made the incident report as required, a full record of the incident form could not be accessed. In discussion during the inspection the manager decided to set up a system that would enable them to record and monitor all accidents and incidents within the home as well as at the provider's central office.

Requires improvement

Is the service safe?

People were protected against environmental risks to their safety and welfare. Staff monitored general environmental risks, such as hot water temperatures, fire exits and slip and trip hazards as part of their routine health and safety checks. The provider had a procedure in place to remove the risk of people being scalded in baths or showers. Staff were required to measure and record the water temperature prior to helping each person with a bath or shower. Those temperatures had all been recorded at less than 40°c for the previous three weeks. The service had recently had all hot water thermostatic monitoring valves replaced on baths and showers. However, during our inspection we found the valves had not been adjusted to limit the hot water temperatures to the Health and Safety Executive recommended water temperature to be no hotter than 44°c. We found one bath was providing hot water in excess of 50°c. The manager immediately contacted the company that had fitted the valves. The manager told us a fitter attended the home the same day and restricted the water temperature as required.

Other general risk reduction measures were in place. For example, where pressure mattresses were in use to reduce the risk of skin breakdown, The staff had recorded the required setting of each person's pressure mattress and those settings were checked and verified before the person was helped into bed. Padded bed rail covers were used to reduce the risk of entrapment where indicated. Appropriate measures were in place regarding infection control. The provider monitored other risks and we saw an up to date electrical installation certificate and legionella risk assessment. Other household equipment and furniture was seen to be in good condition and well maintained. Service contracts were in place to regularly service equipment in use, such as hoists and fire equipment. Emergency plans were in place, for example evacuation plans in case of emergencies.

People were protected by robust recruitment processes. Staff files included all recruitment information required of the regulations. For example, proof of identity, criminal record checks, and evidence of their conduct in previous employments. We found some unexplained gaps in people's employment histories. The manager contacted us shortly after the inspection to confirm those gaps had been explained in writing as required. The service had staff vacancies on the care team and were in the process of recruiting new staff. In the interim period they were using some agency staff. The service had received written confirmation from the agencies of recruitment checks carried out and training provided for each agency member of staff. This ensured, as far as possible, that people were protected from staff being employed who were not suitable.

People's medicines were stored and administered safely. Only staff trained and assessed as competent were allowed to administer medicines. Staff had received medicines training to ensure the right people received the right drug and dosage at the right time. This was confirmed by the staff we spoke with and documented in their training records. Medicines administration record (MAR) sheets were up to date for all oral medications and had been completed by the staff administering the medicines. However, we saw that prescribed items such as topical creams and nutritional supplements were not always administered as indicated on the MAR sheets. For example, one person had been prescribed nutritional supplement drinks one to two times daily. The staff members administering the supplements had signed to say this had been given, making it appear the person had received the full amount prescribed. However, when we looked at the person's fluid charts we saw they had rarely drunk the full amount, on most occasions only having sips recorded. For topical creams, the MAR sheets stated to refer to the daily records for administration by care staff. However, we saw the daily records did not contain details for staff to follow and the GPs prescription was not always followed. This was discussed at the inspection with the manager and a residential care officer. A system was then devised and implemented to make sure that the staff member responsible for the administration of the topical creams and nutritional supplement drinks made sure they were administered as prescribed and as signed for.

The care staff team included the manager and assistant manager, three residential care officers (seniors), 14 care assistants and 12 relief care assistants. Additional staff included two business support staff, four domestic staff, one laundry person, one catering officer, one assistant cook and one handy person. Staffing levels at the time of our inspection were seven care staff and one residential care officer from 8am until 9 or 10pm. Overnight there were three care staff awake and one residential care officer sleeping on the premises and available if needed. People told us staff were available when they needed them. One person said: "I don't wait long at all." and another commented: "I never wait, staff are available." Staff

Requires improvement

Is the service safe?

members felt there were usually enough staff on duty at all time to do their job safely and efficiently. During our observations in the dining room there were ample staff available to assist people eating their meals. There were sufficient staff available at other times. Call bells were answered quickly and staff had time to sit and chat with people as well as providing their care.

Good

Is the service effective?

Our findings

People received effective care and support from staff who knew them well and were well trained.

New staff were provided with induction training. This included a set induction relating to the premises, the provider's policies and procedures and introductions to the people living at the service. Induction training followed the Skills for Care Common Induction Standards (CIS). Practical competencies were assessed for topics such as moving and handling and the administration of medicines before staff were judged to be competent. The manager was aware of the new Care Certificate and the provider was developing plans to move staff induction over to the new Care Certificate training.

People felt staff had the skills they needed when supporting them. One person told us: "they are kind." We observed staff working with people and providing assistance. At all times they were skilful and professional. Ongoing staff training was monitored and we saw all training deemed by the provider as mandatory was up to date. The mandatory training included: fire safety, moving and handling, first aid, food hygiene, safeguarding adults and health and safety. Staff were also provided with training specific to the people they supported. For example, recent training had been a four day course covering dementia. Staff felt they had been provided with training they needed to deliver high quality care and support to the people living at the service.

People benefitted from staff who were well supervised. Staff had regular, three monthly, one to one meetings (supervision) with their manager to discuss their work. Staff felt they were well supported by the managers and found the regular supervision meetings useful. Staff also confirmed they had yearly performance appraisals of their work carried out with their manager.

People's rights to make their own decisions, where possible, were protected. Staff received training in the Mental Capacity Act 2005 (MCA). The MCA provides the legal framework for acting and making decisions on behalf of individuals who lack the mental capacity to make particular decisions for themselves. The MCA also requires that any decisions made on behalf of a person who lacks capacity, are made in the person's best interests. Managers had a good understanding of the MCA and staff were aware of their responsibilities to ensure people's rights to make their own decisions were promoted.

Throughout the inspection we observed staff asking people's permission before providing care or assistance. The care plans did not include evidence of people's consent to their care or agreement with their care plan. The service was in the process of developing new care plans and we saw people's link workers were sitting with the people and discussing every aspect of their new plan. On discussion, the manager decided to include a recording of people's involvement and consent in the new care plans when introduced.

The requirements of the Deprivation of Liberty Safeguards (DoLS) were being met. The DoLS provide legal protection for vulnerable people who are, or may become, deprived of their liberty. The service had assessed people living at the home and, where applicable, had made DoLS applications to the local authorising body appropriately. People were able to access the services of independent mental capacity advocates (IMCA) when needed. One IMCA told us: "I have found staff and managers understanding of the role of the IMCA and informed about deprivations of liberty. I have always been greeted in a welcoming and friendly way, been given access to relevant information and enabled to speak in private with the clients."People told us they enjoyed the meals at the home and most confirmed they were given choices. Some people were not sure if they had been offered choices but knew they could ask for something different if they didn't like what was on the menu on the day. Comments received about the food included: "It is not too bad.", "It is very good." and "the food is very good, I get plenty." Staff used a nationally recognised malnutrition screening tool to identify people at risk. People were weighed every month. On the days of our inspections we saw people were enjoying their lunch which was served hot and was well presented.

People received effective health care and support. People could see their GP and other health professionals such as occupational therapists and chiropodists when needed. Contact sheets showed that specialist health professionals were usually consulted as necessary. The manager contacted appropriate health professionals on the day of our inspection regarding two issues we had identified for individual people. Health professionals confirmed the

Good

Is the service effective?

service worked in partnership with other agencies. They thought the service supported people to maintain good health, have access to healthcare services and receive ongoing healthcare support.

Good

Is the service caring?

Our findings

People were treated with care and kindness. Comments made by people included: "They are kind and caring, they are all good.", "They are not rough, they are very, very careful.", "Most of them are very good" and "They are lovely." A relative told us: "They are marvellous, [Name] never wanted to come here but is happy now."

Three people told us they, or their relatives, had been involved in drawing up their care plans. Others said they couldn't remember. They confirmed staff knew how they liked things done and did them that way. People felt staff listened to them and acted on what they said. People told us: "They are very helpful." and "They ask what I want done and go ahead and do it."

People's wellbeing was protected and all interactions observed between staff and people living at the service were respectful and friendly. People confirmed staff treated them with privacy and dignity. One person told us: "Oh yes, very much so." When asked if they felt staff treated people with respect one relative commented: "Definitely ." and another said: "Definitely, they treat them all with respect."

Staff had received training in equality and diversity. Dignity and privacy was included in people's induction training as part of the common induction standard on person-centred values. People's right to confidentiality was protected. All personal records were kept securely. Visits from health professionals were carried out in private in people's own rooms. We observed staff protected people's rights to privacy and dignity as they supported them during the day and any personal care was carried out behind closed doors. Staff never entered a room without asking permission from the room owner.

Staff knew the people well and care plans contained details about people's histories and personal preferences. Staff were knowledgeable about the people they cared for, their needs and what they liked to do. Staff were aware of people's abilities and their care plans highlighted what people were able to do for themselves. This ensured staff had the information they needed to encourage and maintain people's independence. The relative we spoke with said that staff knew how their family member liked things done and commented: "Ever since [Name] has been there I can't fault it."

Good

Is the service responsive?

Our findings

People received support that was individualised to their personal preferences and needs. Each care plan contained a front sheet entitled: "This is me." The sheet contained details of all aspects of people's lives, likes, dislikes and preferences and was written by the person themselves, with the help of their relatives and/or staff. Staff were aware of the information in those sheets and were able to tailor their care provision and activities to the person's wishes.

The service were developing a new care planning and risk assessment system. Staff were working with each person and their families, where appropriate, to develop and implement new care plans that were more individualised and centred on people as individuals. This has been a work in progress for a number of months and yet to be fully implemented. Where people required specialist equipment or aids to increase their independence, those needs had been assessed and the equipment obtained by the service.

The care plans in place gave details of things people could do for themselves and where they needed support. People's abilities were kept under review and any increased dependence was noted in the daily records and contact sheets. Staff knew what people preferred to be called and used those names when addressing them. Staff knew people's likes and dislikes, which we saw demonstrated during meal times and when staff were working with them at other times.

People were supported to maintain relationships with their family and friends. We saw visitors were welcomed warmly to the home and were offered drinks during their visit. Visitors told us they could visit at any time and were always made welcome.

People had access to planned activities and local community outings. During our inspection people sat and chatted with other people and staff. Activities available included gardening, games and quizzes, bingo and music. People were involved in the local community and visited local shops and leisure facilities. There was a local park and pond area where people sometimes went, weather permitting. On the day of our inspection there was a small "chatterbox" group taking place. This involved looking at old photographs and talking about the subject. People were animated and enjoying talking about events in their lives they had been reminded of by the photographs. Later in the day someone had arrived and provided musical entertainment. People commented: "I like sitting and chatting.", "I like the music." Another person told us: "I go for a walk sometimes with staff. I love bingo!"

In late 2014 the provider contacted an occupational therapist to work with the service in developing the facilities and service provided to people living at the home as well as working with the staff group. Since that time the occupational therapist spent one day a week at the service. Many improvements had been made. The environment had been enhanced to make it more dementia friendly. Seating in communal areas had been split into smaller groups to encourage socialisation. Other improvements had included more dementia signage to help people find their way around and improved lighting. Part of this work included reducing risks to people and staff and promoting people's participation and activity. Staff all commented on the improvements and were enthusiastic about the changes taking place. A health professional told us they had seen many improvements over the past year. Another professional told us: "My impression of the service is that it is welcoming, and has a warm and active atmosphere. The communal environment enables small group interaction rather than everyone sitting around the edges of the room. There appears to be a stimulating activities programme. I have observed staff interaction with clients and feel they are kind, respectful and polite. They appear to encourage and respect individuality and independence."

People were aware of how to make a complaint and told us they would speak to one of the managers. Complaints were dealt with quickly and resolutions were recorded along with actions taken. Both visiting relatives said they had never had to complain but knew who to talk to.

Good

Is the service well-led?

Our findings

People benefitted from living at a service that had an open and friendly culture. People felt staff were happy working at the service. One person said: "I think they are." and another commented: "They are very happy."

Over the past 15 months the service had seen a number of changes and many improvements had been made to the service provided. This work remained ongoing and the manager explained current work underway. For example, new care planning systems were being developed and introduced and refurbishment and refurnishing was continuing. The provider had reduced the beds being used to allow the work to be completed with as little disruption as possible to the people living at the service. Staff were enthusiastic about the changes and felt the changes made were for the better. Comments received from staff included: "The manager has put a lot in place, I admire what he has done.", "The manager and residential care officers all listen.", and "There have been lots of improvements. Staff are happier and enjoying their job more."

Staff told us the management was open with them and communicated what was happening at the service and with the people living there. Staff felt they had the tools and training they needed to do their jobs properly and fulfil their duties and responsibilities. Staff said they got on well together and that management worked with them as a team.

The provider carried out annual quality surveys with people living at the service. The next survey was due to be carried out in September 2015. Once the survey forms were returned and analysed a report would be written of the results and the manager would draw up an action plan to deal with any issues raised.

The provider had a number of quality assurance systems in place. Those systems included unannounced visits by a representative of the provider and spot checks by the nominated individual. The provider visits audited areas of the management and running of the service. For example, checks on health and safety, concerns and complaints and maintenance issues related to the premises. Food safety and kitchen checks were carried out by the catering officer and assistant chef. The home had been awarded a food hygiene rating of 4 (good) by Bracknell Forest Council.

The provider had a number of quality assurance and health and safety checks in place. Those included fire equipment operation checks, emergency lighting checks, fire drills and a daily audit of medicine administration records. Systems were in place to monitor and record staff training and the manager and assistant manager oversaw staff supervision and annual staff appraisals.

The service did not have a registered manager in place. However the new manager was nearing the end of the CQC registration process. All other registration requirements were being met and the manager ensured that notifications were sent to us when required. Notifications are events that the registered person is required by law to inform us of. Management records were up to date and kept confidential where required. However, people's care plans and risk assessments were not all up to date. There was no management system in place to monitor and ensure people's individual care records were accurate, complete and up to date. This was identified to the manager who advised us they would develop and implement a monitoring system without delay.

People benefitted from a staff team that were happy in their work. Staff told us they enjoyed working at the service. They felt supported by the management and their colleagues when working at the service. They felt encouraged to make suggestions and felt the management took their suggestions seriously.

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 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: The provider had not established a system to enable the registered person to maintain an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user. Regulation 17 (2) (c).