Commission for Social Care Inspection

Making Social Care Better for People

Inspecting for better lives

Key inspection report

Care homes for adults (18-65 years)

Name:	Heathers
Address:	North Walsham Rd Witton Norfolk NR28 9TP

The quality rating for this care home is:	one star adequate service

A quality rating is our assessment of how well a care home, agency or scheme is meeting the needs of the people who use it. We give a quality rating following a full assessment of the service. We call this a 'key' inspection.

Lead inspector:	**Date:**							
Janie Buchanan	1	0	0	3	2	0	0	9

This is a report of an inspection where we looked at how well this care home is meeting the needs of people who use it. There is a summary of what we think this service does well, what they have improved on and, where it applies, what they need to do better. We use the national minimum standards to describe the outcomes that people should experience. National minimum standards are written by the Department of Health for each type of care service.

After the summary there is more detail about our findings. The following table explains what you will see under each outcome area.

Outcome area (for example Choice of home)

These are the outcomes that people staying in care homes should experience. They reflect the things that people have said are important to them:

This box tells you the outcomes that we will always inspect against when we do a key inspection.

This box tells you any additional outcomes that we may inspect against when we do a key inspection.

This is what people staying in this care home experience:

Judgement:

This box tells you our opinion of what we have looked at in this outcome area. We will say whether it is excellent, good, adequate or poor.

Evidence:

This box describes the information we used to come to our judgement.

Copies of the National Minimum Standards – Care Homes for Adults (18-65 years) can be found at www.dh.gov.uk or bought from The Stationery Office (TSO) PO Box 29, St Crispins, Duke Street, Norwich, NR3 1GN. Tel: 0870 600 5522. Online ordering from the Stationery Office is also available: www.tso.co.uk/bookshop

The Commission for Social Care Inspection aims to:

- Put the people who use social care first
- Improve services and stamp out bad practice
- Be an expert voice on social care
- Practise what we preach in our own organisation

Our duty to regulate social care services is set out in the Care Standards Act 2000.

Reader Information

Document Purpose	Inspection report
Author	CSCI
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Information about the care home

Name of care home:	Heathers
Address:	Witton North Walsham Rd Norfolk NR28 9TP
Telephone number:	TBC
Fax number:	
Email address:	
Provider web address:	

Name of registered provider(s):	Jeesal Residential Care Services Limited
Type of registration:	care home
Number of places registered:	7

Conditions of registration:		
Category(ies) :	Number of places (if applicable):	
	Under 65	Over 65
learning disability	7	0

Additional conditions:

The maximum number of service users who can be accommodated is 7.

The registered person may provide the following category of service only: Care home only - Code PC to service users of the following gender: Either whose primary care needs on admission to the home are within the following categories: Learning disability - Code LD

Date of last inspection								

Brief description of the care home

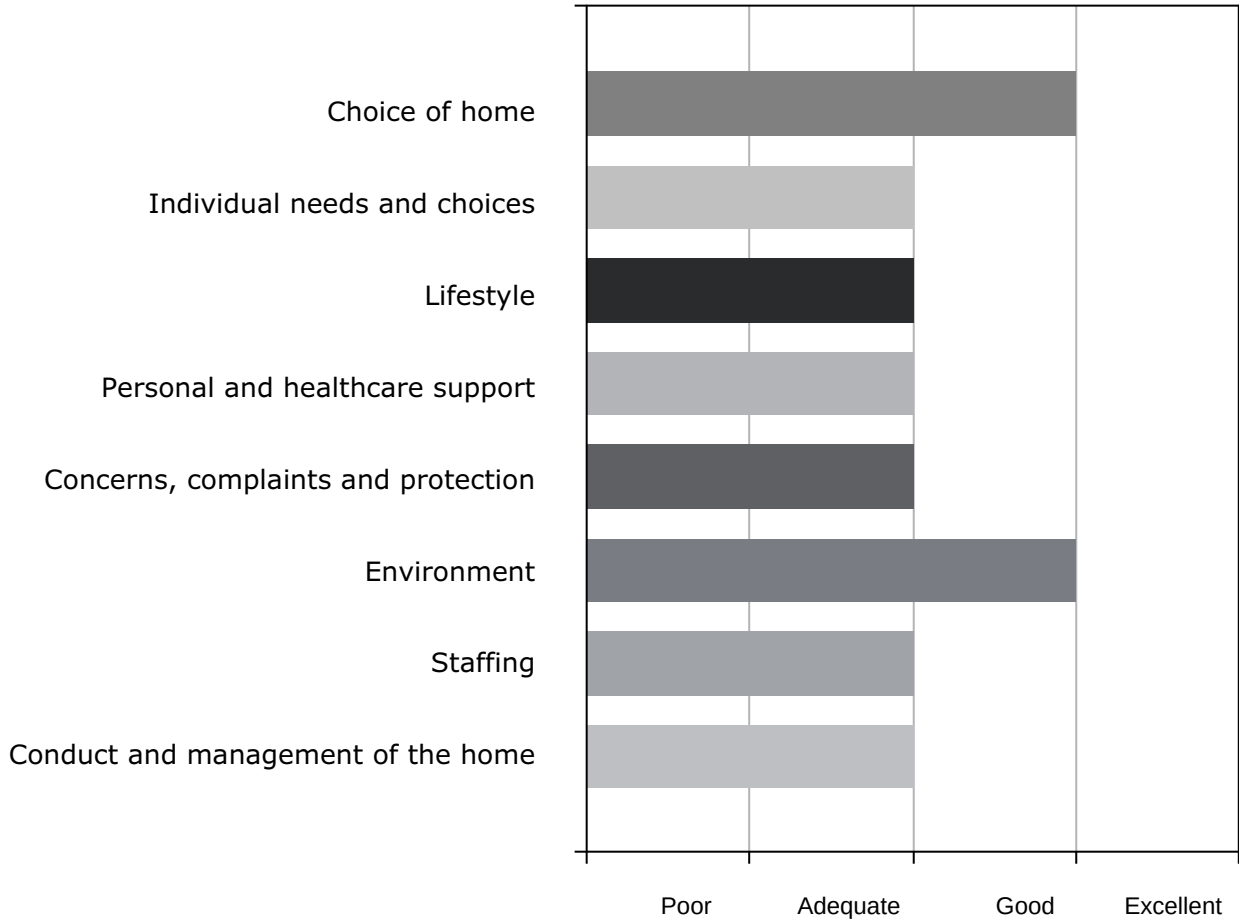
The Heathers is owned and managed by Jeesal Residential Care Services Ltd who own 10 other care homes in Norfolk. It provides accommodation and support to 7 people with a learning disability and complex behaviors resulting from autism. The premsies are made up of two main buidlings within a few yards of each other. The first is a converted barn with 3 one bedded units and one two bedded unit. The second building has two single units. There is a manager who is supported by 2 deputies, seven senior staff and a number of support workers. Charges start at a base rate of £1400 per week, with additional costs depending upon people's individual needs.

Summary

This is an overview of what we found during the inspection.

The quality rating for this care home is:	one star adequate service

Our judgement for each outcome:



How we did our inspection:

For this inspection we The Commission for Social Care Inspection looked at all the information that we have received about the service. This included the annual quality assurance assessment (AQAA) that was sent to us by the home. The AQAA is a self-assessment document that focuses on how well outcomes are being met for residents living there. It also gave us some numerical information. We received completed 8 surveys from residents staff and relatives and we also talked to a relative by telephone after our inspection.

We visited the home and talked with two residents, four members of staff and the manager. We undertook a brief tour of the premises and checked medication administration and storage. We also checked a range of the home's files and

paperwork.

Four requirements and four recommendations have been made as a result this inspection.

What the care home does well:

Residents live in spacious, comfortable accommodation that has been adapted to meet their individual needs. Those we spoke to told us they liked living at The Heathers. One told us: 'it's a nice place staff are good to me, I like them all'. Another reported: 'staff are alright with me'

Most relatives told us that they felt the home met the needs of their resident well that staff had the right skills to look after people properly and the home kept them up to date with important issues. One stated: 'I feel my son is in a happy safe and healthy environment'.

Staff who completed our survey felt they received good information about the needs of the people they were to support and they were given training that was relevant to their role.

What has improved since the last inspection?

This is the home's first inspection since it became registered with us.

What they could do better:

The location of the home is remote, not easily accessible with poor public transport links making residents completely dependent on staff to access local facilities. There is little the home can do to remedy this.

Residents' care plans need to be better laid out and organised so that key information is easy to find. Information in the plans needs to be signed and dated so that people reading them know that it is relevant and up to date. The plans must also accurately reflect residents' actual routines. Mangers at the home must ensure that staff are aware of the information in people's plans, in particular how to manage their challenging behaviour, so that residents receive consistent , comprehensive and effective support no matter who is assisting them.

Medication recording and administration must improve so that there is a clear and accurate record for what residents have been given and so that they receive their medication safely.

Staff should receive regular and recorded supervision from their managers so they have the opportunity to raise their concerns, receive feedback about their working practices and so their training needs can be identified.

Proper pre-employment checks and references must be obtained for all prospective workers so that residents are protected and only suitable people are employed to work with vulnerable adults.

Complaints and concerns raised by residents or their advocates need to be recorded, investigated thoroughly and responded to quickly and effectively so that they can be confident their concerns are taken seriously.

The many problems staff raised with us need to be addressed quickly to improve their morale and to ensure they work as an effective team to meet residents' needs.

Fire doors must not be pinned back as this prevents them closing in the event of a fire and puts residents at unnecessary risk. Hot water temperatures must also be closely monitored so that residents are not at risk of scalding themselves.

The home has got off to a shakey start and now needs strong leadership to bring much needed cohesion and direction to the staff team, and to address the shortfalls this report has identified.

If you want to know what action the person responsible for this care home is taking following this report, you can contact them using the details set out on page 4.

The report of this inspection is available from our website www.cqc.org.uk. You can get printed copies from enquiries@cqc.org.uk or by telephoning our order line –0870 240 7535.

Details of our findings

Contents

Choice of home

These are the outcomes that people staying in care homes should experience. They reflect the things that people have said are important to them:

People are confident that the care home can support them. This is because there is an accurate assessment of their needs that they, or people close to them, have been involved in. This tells the home all about them, what they hope for and want to achieve, and the support they need.

People can decide whether the care home can meet their support and accommodation needs. This is because they, and people close to them, can visit the home and get full, clear, accurate and up to date information. If they decide to stay in the home they know about their rights and responsibilities because there is an easy to understand contract or statement of terms and conditions between the person and the care home that includes how much they will pay and what the home provides for the money.

This is what people staying in this care home experience:

Judgement:

People using this service experience **good** quality outcomes in this area. We have made this judgement using a range of evidence, including a visit to this service.

The home's admission procedures are good, ensuring that people know their needs can be met there

Evidence:

A senior manager from within the company completes all pre-admission assessments for prospective residents and we viewed good pre-admission information on the files that we checked. During our inspection one prospective resident was visiting the home with her social worker and advocate to assess its facilities and decide whether or not she wanted to live there. One relative described her daughters transition from her previous home to The Heather as 'brilliant I was heavily involved as were the speech and behaviour therapists. Staff from The Heathers even went work at my daughter's previous home to see how she was supported there'. Most admissions are planned carefully over a period of time to give prospective residents and staff a chance to see if the placement is suitable. Both residents we talked to told us they had visited the home before moving in and one came every day for a week to see if he liked it. However there has been one serious placement breakdown when one resident only

Evidence:

stayed for 2 days before wanting to leave. This resident had not had the opportunity to visit the home first.

Individual needs and choices

These are the outcomes that people staying in care homes should experience. They reflect the things that people have said are important to them:

People's needs and goals are met. The home has a plan of care that the person, or someone close to them, has been involved in making. People are able to make decisions about their life, including their finances, with support if they need it. This is because the staff promote their rights and choices. People are supported to take risks to enable them to stay independent. This is because the staff have appropriate information on which to base decisions.

People are asked about, and are involved in, all aspects of life in the home. This is because the manager and staff offer them opportunities to participate in the day to day running of the home and enable them to influence key decisions. People are confident that the home handles information about them appropriately. This is because the home has clear policies and procedures that staff follow.

This is what people staying in this care home experience:

Judgement:

People using this service experience **adequate** quality outcomes in this area. We have made this judgement using a range of evidence, including a visit to this service.

Residents' needs must be accurately recorded in their plans of care and staff must be aware of them so they deliver appropriate care.

Evidence:

Residents have their own support plan that is in a format suitable for their individual communication needs. There is additional information about each resident in a separate file for staff, and also a diary that is completed daily with residents. We checked the plans for two residents. The general layout of the plans was confusing and we struggled to easily find important information about residents such as their risk assessments and weight recording. Some of the information, although detailed, was not signed or dated so it was not possible to tell if it was current and relevant. However, one relative who has a copy of her daughter's plan told us that it was pretty detailed and reflected her needs well. She told us that the plan clearly stated that her daughter is allergic to all citrus fruits but despite this, she had found a fresh orange and some orange marmalade in her daughter's fridge when she visited. We sat with

Evidence:

one resident and went through his plan with him. This was satisfactory but needed to contain clearer guidance for staff about how to manage his constant requests for cigarettes. The daily chart used to monitor this resident's cigarette intake had not been updated for sometime so there was no way of knowing how many cigarettes the resident had actually been given that day.

The plans did contain information about how to communicate with residents but one relative felt that staff didn't communicate particularly well with her daughter. She told us that although her daughter knows over 500 words in Maketon staff rarely use this communication method with her. On one occasion staff asked her what a particular sign that her daughter was making meant. The relative told us it was a very common Maketon sign for a drink that staff had failed to recognize. She also told us that staff regularly talk in front of her daughter as though her daughter isn't there.

Lifestyle

These are the outcomes that people staying in care homes should experience. They reflect the things that people have said are important to them:

Each person is treated as an individual and the care home is responsive to his or her race, culture, religion, age, disability, gender and sexual orientation. They can take part in activities that are appropriate to their age and culture and are part of their local community. The care home supports people to follow personal interests and activities. People are able to keep in touch with family, friends and representatives and the home supports them to have appropriate personal, family and sexual relationships. People are as independent as they can be, lead their chosen lifestyle and have the opportunity to make the most of their abilities. Their dignity and rights are respected in their daily life. People have healthy, well-presented meals and snacks, at a time and place to suit them.

People have opportunities to develop their social, emotional, communication and independent living skills. This is because the staff support their personal development. People choose and participate in suitable leisure activities.

This is what people staying in this care home experience:

Judgement:

People using this service experience **adequate** quality outcomes in this area. We have made this judgement using a range of evidence, including a visit to this service.

Residents have access to a limited range of activities and leisure pursuits.

Evidence:

The home is in a very remote location making residents dependent on staff to get anywhere. However there are 3 vehicles available for staff to drive and one resident told us that he had been out in one that morning to get his paper and cigars. Another resident attends a day centre in Norwich, some 15 miles away. One resident is from the traveling community and staff told us that they had obtained an old car for him to work on as this is something he used to enjoy in this community. However we received conflicting evidence about the level of activity undertaken by residents. Managers told us that residents regularly get taken out to nearby seaside villages and go ten-pin bowling however staff told us that :'residents never get taken out anymore'. One staff member told us a resident requested to go out in the mini bus the previous Sunday

Evidence:

but there were not enough staff available to take him. Another member of staff reported that there had been no trips out since Christmas apart from shopping and one resident had been to the pub. One relative told us: 'I feel there is a lack of daily activity to stimulate my daughter throughout the day and evening. I think she is becoming bored and that is why she's started tearing her clothes'. In one resident's care plan it stated that he went horse riding weekly. However we discovered this was only in the summer and he had in fact not been horse riding once since he had moved in at Christmas.

Most relatives who completed our survey told us that the home helped their friend or relative keep in touch with them. However one relative stated: 'it was suggested and agreed that we would be contacted weekly by our daughter's key worker to update us on any health behavioral communication issues and how her week in general had been. This was agreed on 09/01/09 since then we have only received two calls'.

Personal and health care support

These are the outcomes that people staying in care homes should experience. They reflect the things that people have said are important to them:

People receive personal support from staff in the way they prefer and want. Their physical and emotional health needs are met because the home has procedures in place that staff follow. If people take medicine, they manage it themselves if they can. If they cannot manage their medicine, the care home supports them with it in a safe way.

If people are approaching the end of their life, the care home will respect their choices and help them to feel comfortable and secure. They, and people close to them, are reassured that their death will be handled with sensitivity, dignity and respect, and take account of their spiritual and cultural wishes.

This is what people staying in this care home experience:

Judgement:

People using this service experience **adequate** quality outcomes in this area. We have made this judgement using a range of evidence, including a visit to this service.

Staff do not have the information they need to deal with residents' challenging behaviour and to ensure they are supported in a consistent way. Medication recording needs to improve so there is a clear record of what residents have received.

Evidence:

Residents' health care needs were documented in their support plans as was guidance for staff in how to manage any challenging behaviour. Staff also receive training in deescalation techniques and restraint. One resident has behaviour that particularly challenges and regularly hits bites and nips staff. What was very concerning was that two members of staff told us they were not aware, and had not read, this person's behaviour management plan and in fact gave us differing accounts of how they deal with her.

We checked medication storage a sample of medication administration records (MAR). We noted the following shortfalls; a number of handwritten additions to the printed MAR sheets had not been signed or dated or checked by a second person to ensure their accuracy; no explanation on the MAR sheet was given when there was a change

Evidence:

to prescriber's instructions; a number of tablets for a future date had been removed from a one resident's blister pack there was no explanation as to why this was and it can only be assumed that the resident has been given the medication wrongly and there were numerous signature gaps on the MAR sheets where it was not possible to tell if someone had received their medication or not. The home has an adequate medication policy that covers the administration disposal recording and refusal of medications. However the policy is undated and there was no evidence that it has been reviewed to check it is still in line with current legislation and practice. The policy states that staff must read it every 6 months however a number of staff had not read it in over a year.

Concerns, complaints and protection

These are the outcomes that people staying in care homes should experience. They reflect the things that people have said are important to them:

If people have concerns with their care, they or people close to them, know how to complain. Their concern is looked into and action taken to put things right. The care home safeguards people from abuse, neglect and self-harm and takes action to follow up any allegations.

There are no additional outcomes.

This is what people staying in this care home experience:

Judgement:

People using this service experience **adequate** quality outcomes in this area. We have made this judgement using a range of evidence, including a visit to this service.

Residents do have access to a complaints procedure but their concerns, and those of their advocates , are not always addressed satisfactorily.

Evidence:

Details of the home's complaints procedure are included in its statement of purpose and service users' guide and there is a simplified, pictorial version to help residents understand it. When we asked relatives if the home responded appropriately when they raised concerns one told us: 'they always listen to what I have to say or ask'. However another told us of a long list of concerns she had raised with staff and managers but felt that they had rarely responded in a timely matter and many issues remained unresolved. She stated: 'we have called meetings with managers to raise our concerns solutions were discussed but few have been met'.

Staff told us that they do receive training in protecting vulnerable adults and training files we checked further evidenced this. Staff we spoke to showed a good knowledge of the different types of abuse that a vulnerable adult can face and felt confident about reporting if they had concerns. However they were less sure of local guidelines and who they should contact in the local adult protection teams.

Environment

These are the outcomes that people staying in care homes should experience. They reflect the things that people have said are important to them:

People stay in a safe and well-maintained home that is homely, clean, comfortable, pleasant and hygienic.

People stay in a home that has enough space and facilities for them to lead the life they choose and to meet their needs. The home makes sure they have the right specialist equipment that encourages and promotes their independence. Their room feels like their own, it is comfortable and they feel safe when they use it. People have enough privacy when using toilets and bathrooms.

This is what people staying in this care home experience:

Judgement:

People using this service experience **good** quality outcomes in this area. We have made this judgement using a range of evidence, including a visit to this service.

Residents live in a spacious, homely and comfortable environment.

Evidence:

Finding the home is extremely difficult as it has been built on an unnamed road and there are no signposts indicating where it is. It is also in a remote location limiting residents' opportunities for getting out and isolating them from the community. However it is quiet and one relative told us: 'my daughter likes it quiet and this is right for her'. The home itself is made up of two main buildings within a few yards of each other. The first is a converted barn with 3 one bedded units and one two bedded unit. The second building has two single bedrooms. Each person has their own spacious living unit with their own front door, kitchen and bathroom. We visited all the units and each was clean and comfortably furnished. Some pieces of furniture have been adapted and secured to make them safer of residents.

Staffing

These are the outcomes that people staying in care homes should experience. They reflect the things that people have said are important to them:

People have safe and appropriate support as there are enough competent, qualified staff on duty at all times. They have confidence in the staff at the home because checks have been done to make sure that they are suitable. People's needs are met and they are supported because staff get the right training, supervision and support they need from their managers.

People are supported by an effective staff team who understand and do what is expected of them.

This is what people staying in this care home experience:

Judgement:

People using this service experience **adequate** quality outcomes in this area. We have made this judgement using a range of evidence, including a visit to this service.

Residents receive their support from competent and well trained staff, however staff recruitment needs to be tighter to ensure they are adequately protected.

Evidence:

Staff training is good with more that 50 % holding an NVQ level 2 or above. We checked the training files for the staff on duty and all had completed mandatory training as well as specific training to meet the needs of residents such as autism awareness and non- physical intervention techniques.

Staffing levels vary throughout the day depending on residents' needs but there is always a minimum of three staff on duty plus additional staff at key times throughout the day. However one relative told us that her daughter is meant to have two members of staff to support her 14 hours a day. However there have been occasions she has visited and there is only one member of staff available. Staff also told us that there were frequent staff shortages at the home which seriously affected the quality of care that residents received.

Staff we spoke to described their morale as low and were clearly feeling unsupported and negative. There were clear discrepancies between what managers told us about

Evidence:

the service and what staff told us. These misperceptions were concerning and must be addressed. We checked the supervision records for a sample of staff which showed that they were not receiving it as frequently as recommended by the minimum standards and one staff member told us she had only received one supervision in the last 6 months.

We checked the personnel files for 3 members of staff these showed that staff were frequently employed before full CRB checks had been obtained by the home. Although the Department of Health guidance states this is acceptable in 'exceptional circumstances only' it is not good practice to do so and puts residents at unnecessary risk. Both references for one staff member had been obtained from his former employer despite him working in a variety of care settings previously.

Conduct and management of the home

These are the outcomes that people staying in care homes should experience. They reflect the things that people have said are important to them:

People have confidence in the care home because it is run and managed appropriately. People's opinions are central to how the home develops and reviews their practice, as the home has appropriate ways of making sure they continue to get things right. The environment is safe for people and staff because health and safety practices are carried out.

People get the right support from the care home because the manager runs it appropriately, with an open approach that makes them feel valued and respected. They are safeguarded because the home follows clear financial and accounting procedures, keeps records appropriately and makes sure staff understand the way things should be done.

This is what people staying in this care home experience:

Judgement:

People using this service experience **adequate** quality outcomes in this area. We have made this judgement using a range of evidence, including a visit to this service.

Management of the home has not been stable causing instability and a lack on continuity for staff and residents.

Evidence:

The current registered manager has returned to another home within the company and a new manager was appointed at the beginning of February 2009. Staff told us they found this unsettling. The new manager is a registered mental health nurse and was previously registered with the Health Care Commission as the manager of a secure unit. He is about to apply to register with us so we have not yet had the opportunity to assess his fitness to run a home. However one relative felt confident that he was responding to her concerns and seemed to be taking them much more seriously that the previous manager. Staff were unsure about his management style and were clearly hostile to some of the changes he had introduced.

The home has a range of policies to guide staff in their working practices however there was little evidence that these polices had been reviewed regularly to check that

Evidence:

they still complied with current legislation and good practice.

We checked a number of records in relation to health and safety including (portable appliance testing fridge temperatures and fire records) which showed us that the home regularly checks and maintains its equipment. However the temperature of hot water outlets is not checked regularly and should be to prevent the risk of residents scalding themselves. We also saw a fire door propped open in one of the residents flats thereby preventing it from closing fully in the event of a fire.

Are there any outstanding requirements from the last inspection?				
	Yes	☐	No	☑

Outstanding statutory requirements

These are requirements that were set at the previous inspection, but have still not been met. They say what the registered person had to do to meet the Care Standards Act 2000, Care Homes Regulations 2001 and the National Minimum Standards.

No.	Standard	Regulation	Requirement	Timescale for action

Requirements and recommendations from this inspection:

Immediate requirements:

These are immediate requirements that were set on the day we visited this care home. The registered person had to meet these within 48 hours.

No.	Standard	Regulation	Requirement	Timescale for action

Statutory requirements

These requirements set out what the registered person must do to meet the Care Standards Act 2000, Care Homes Regulations 2001 and the National Minimum Standards. The registered person(s) must do this within the timescales we have set.

No.	Standard	Regulation	Requirement	Timescale for action
1	6	15	Care and support plans must accurately reflect residents' needs and staff must be aware of their contents so that they can offer consistent and comprehensive care to residents	01/05/2009
2	20	17	The home's medication records and administration must improve so there is a clear and accurate record of what residents have received.	01/05/2009
3	42	13	Hot water temperatures must be regularly monitored so that residents are not at risk of scalding themselves	01/04/2009
4	42	4	Fire doors must not be held back so that they are prevented from closing in the event of a fire	01/04/2009

Recommendations

These recommendations are taken from the best practice described in the National Minimum Standards and the registered person(s) should consider them as a way of improving their service.

No.	Refer to Standard	Good Practice Recommendations
1	22	Staff should receive training in the specific adult protection system in their local area
2	34	Full CRB checks should be obtained before anyone starts working at the home so that residents are protected.
3	36	Staff should have regular, recoded supervision at least six times a year so they receive the support they need to carry out their job.
4	40	The home's policies and procedures should be regularly reviewed to monitor if they meet the requirements of current legislation and good practice

Helpline:

Telephone: 03000 616161 or
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