Review of compliance

Herons Lea Residential Home Limited Herons Lea Residential Home Limited	
Region:	South West
Location address:	Silford Cross Westward Ho! Bideford Devon EX39 3PT
Type of service:	Care home service without nursing
Date of Publication:	June 2012
Overview of the service:	Heron's Lea provides accommodation with care for up to 20 people. The service is designed for older people who may be physically or mentally frail.

Summary of our findings
for the essential standards of quality and safety

Our current overall judgement

Herons Lea Residential Home Limited was not meeting one or more essential standards. Action is needed.

The summary below describes why we carried out this review, what we found and any action required.

Why we carried out this review

We carried out this review as part of our routine schedule of planned reviews.

How we carried out this review

We reviewed all the information we hold about this provider, carried out a visit on 3 May 2012, checked the provider's records, observed how people were being cared for, looked at records of people who use services, talked to staff, reviewed information from stakeholders and talked to people who use services.

What people told us

We visited Heron's Lea on Thursday 3 May 2012 between 10am and 5:45pm. We visited four people who lived there in their private rooms and spoke with or observed all other people in the lounge or dining room. We met with three people who were friends or relatives of people in the home and who had visited frequently.
We met with the registered manager and three staff on duty. We also looked at the daily records relating to the care and support people received. Later we phoned District Nurses who had visited regularly.

One person said, "I can't fault anything. The staff are nice, the food is nice – I've never eaten so much in my life." This person liked to eat in their room, but would go to the lounge when there was musical entertainment.

One relative thought their family member had "a lovely room, staff they enjoy and good company". They confirmed that at the time of admission they were given a contract and they were aware that the home might not always be able to suitably care for a person if their care needs increased significantly.

We saw, after serving lunch, care staff brought their packed lunches to the lounge, and sat with the people who lived in the home. They gently coaxed and encouraged people who were still eating to eat their food, with cheerful smiles.

Health care professionals who had visited the home regularly told us that they had always found staff to be helpful and caring, and had observed a good standard of care.

Staff said they found that confidentiality was respected.

Staffing levels at night had been increased so that there were two awake staff (rather than one awake and one sleeping-in in case they were needed). This was so that they could meet the increased needs of more highly dependent people.

Suitable arrangements for storing medication had been provided. Although we saw that staff worked with care, a system of delivering medication was in use that is not approved by professional bodies, and may result in unsafe delivery of medication.

What we found about the standards we reviewed and how well Herons Lea Residential Home Limited was meeting them

Outcome 01: People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run

People were encouraged to express their views and were involved in making decisions about their care and welfare.

The provider was meeting this standard.

Outcome 04: People should get safe and appropriate care that meets their needs and supports their rights

People's needs were assessed and care and treatment was planned and delivered in line with their individual care plan.

The provider was meeting this standard.

Outcome 06: People should get safe and coordinated care when they move between different services

People's health, safety and welfare was protected when more than one provider was involved in their care and treatment. This was because the provider worked in co-operation with others.

The provider was meeting this standard.

Outcome 07: People should be protected from abuse and staff should respect their human rights

People who use the service were protected from the risk of abuse, because the provider had taken reasonable steps to identify the possibility of abuse and prevent it from happening.

The provider was meeting this standard.

Outcome 09: People should be given the medicines they need when they need them, and in a safe way

Safe storage facilities had been provided for medication.
The registered person had not made an appropriate arrangement for the safe administration of medicines as medicines were not administered directly to people from the labelled containers provided by the pharmacy.

The provider was not meeting this standard. We judged that this had a moderate impact on people using the service and action was needed for this essential standard. This is a breach of Regulation 13 of the Health and Social Care Act 2008.

Outcome 14: Staff should be properly trained and supervised, and have the chance to develop and improve their skills

Staff received appropriate professional support and development.

The provider was meeting this standard.

Outcome 16: The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care

The provider had an effective system in place to identify, assess and manage risks to the health, safety and welfare of people using the service.

The provider was meeting this standard.

Actions we have asked the service to take

We have asked the provider to send us a report within 28 days of them receiving this report, setting out the action they will take. We will check to make sure that this action has been taken.

Where we have concerns we have a range of enforcement powers we can use to protect the safety and welfare of people who use this service. When we propose to take enforcement action, our decision is open to challenge by a registered person through a variety of internal and external appeal processes. We will publish a further report on any action we have taken.

Other information

Please see previous reports for more information about previous reviews.

What we found for each essential standard of quality and safety we reviewed

The following pages detail our findings and our regulatory judgement for each essential standard and outcome that we reviewed, linked to specific regulated activities where appropriate.

We will have reached one of the following judgements for each essential standard.

Compliant means that people who use services are experiencing the outcomes relating to the essential standard.

Where we judge that a provider is non-compliant with a standard, we make a judgement about whether the impact on people who use the service (or others) is minor, moderate or major:

A minor impact means that people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

A moderate impact means that people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

A major impact means that people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly.

Where we identify compliance, no further action is taken. Where we have concerns, the most appropriate action is taken to ensure that the necessary changes are made.

More information about each of the outcomes can be found in the *Guidance about compliance: Essential standards of quality and safety*

Outcome 01:
Respecting and involving people who use services

What the outcome says

This is what people who use services should expect.

People who use services:
* Understand the care, treatment and support choices available to them.
* Can express their views, so far as they are able to do so, and are involved in making decisions about their care, treatment and support.
* Have their privacy, dignity and independence respected.
* Have their views and experiences taken into account in the way the service is provided and delivered.

What we found

Our judgement

The provider is compliant with Outcome 01: Respecting and involving people who use services

Our findings

What people who use the service experienced and told us
"They know how I like my coffee," said one person. We saw staff take the tray with coffee, milk and sugar so that drinks could be made up according to taste.

Visitors to the home that we met had recently supported their relatives to move in. One said that the manager had asked them about their relative's daily routine and their normal arrangements for chiropody, hairdressing, and exercise. They had been given contracts to be clear about what the service included and they were aware that there was a limit to the level of care that this service could provide.

Other evidence
Two people were sharing a room. They were not able to express a view as to whether they wished to share. The provider told us that a full discussion had taken place with both occupants and their families before they moved in together, and that all parties were in agreement. Curtains had been fitted to provide privacy for both the occupants of the shared room. They had high care needs and were cared for in their beds. All other rooms were for single occupation.

We saw one bedroom that had a simple working lock that would be useful to the occupant if they wished to protect their privacy or their belongings. Not all bedroom

doors had locks that the occupant could use. People who lived in the home had gone uninvited into one person's room. The room in question was near the kitchen, and people had taken their cups into the bedroom to wash. A notice had been put on the door, clearly saying "Private" and this had worked.

Staff told us, and we observed, that "We do things when they are ready, not when we are." During the handover from the morning staff to the late shift, staff said that "The ladies who usually like to get up early had a lie-in today." We saw that staff treated people with respect and helped them maintain their dignity. We saw in staff records that when staff had been well meaning but abrupt, the manager had brought this to their attention, as it was not an appropriate way to approach people.

Personal histories had been introduced as part of people's care planning and the staff had gathered, and were still gathering, information about people's past lives and current family. A visitor told us that when their relative recently had a health crisis, and they could not be contacted, the manager had used this information to contact another member of the family. This showed good efforts to involve the family at a time of crisis.

Our judgement
People were encouraged to express their views and were involved in making decisions about their care and welfare.

The provider was meeting this standard.

Outcome 04:
Care and welfare of people who use services

What the outcome says

This is what people who use services should expect.

People who use services:
* Experience effective, safe and appropriate care, treatment and support that meets their needs and protects their rights.

What we found

Our judgement

The provider is compliant with Outcome 04: Care and welfare of people who use services

Our findings

What people who use the service experienced and told us
One person who lived in the home said, "If I need to pull the cord there will be a carer here in a few minutes. They accommodate my requirements – I speak as I find."
Another person was pleased that arrangements had been made to enable them to go swimming once a week. This had been a regular part of their life before moving to Heron's Lea, and they felt more settled now they could swim again.
One person told us that while they lived in their own home they had not been able to see an optician for 20 years and they were delighted to be attended at the home for an eye test.

Other evidence
We looked at the care records of three people with high care needs. We saw that the two hourly "Comforts round log" was well kept, showing what had been done for each person to assure their well being. This included assessments of their skin, whether they had been turned in their bed, offered fluids, whether they were in pain and what was done about it, and bed rails checked to make sure they were positioned correctly.
Care plans showed good practical details about the care that people needed, which is vital when people may be unable to tell staff what they need and want. These covered personal hygiene, diet, medication, night care needs, and mobility. We saw that the normal practice was to review these care plans monthly to ensure they remained accurate. We saw that a care plan had not been updated to match a revised risk assessment with respect to moving and handling. This showed what detailed work was needed to keep good systems up to date to make sure that all staff were following the correct guidance. Staff we saw were working together to provide safe care.

We saw from records kept that District Nurses (DNs) had visited regularly to monitor and treat people with nursing needs. A DN who visited regularly told us that, when caring for people with complex needs, staff at Heron's Lea had followed guidance from the nurses, had initiated requests appropriately, and brought concerns to the attention of the nurses sooner rather than later.

The manager told us that pressure mats had been introduced in the past year. These are mats that can be placed beside people's bed that sound the alarm to alert night staff when someone gets out of bed. Six were in use at the time of this visit in the rooms of people who had been assessed as at risk of falling. The manager had seen that this had reduced the incidence of people walking about the home by night, as staff could attend as soon as they got out of bed during the night and give the support they needed. She had observed that about half of people living in the home did not use their call bell when they needed help and said this measure had reduced their risk of falling.

Our judgement
People's needs were assessed and care and treatment was planned and delivered in line with their individual care plan.

The provider was meeting this standard.

Outcome 06:
Cooperating with other providers

What the outcome says

This is what people who use services should expect.

People who use services:
* Receive safe and coordinated care, treatment and support where more than one provider is involved, or they are moved between services.

What we found

Our judgement

The provider is compliant with Outcome 06: Cooperating with other providers

Our findings

What people who use the service experienced and told us
Relatives were pleased with the support and co-operation shown by the staff and management at the home when their family member was moving in to Heron's Lea.

Other evidence
We found that the manager had accepted assessments from health and social care workers when assessing whether the home could suitably offer a service to a new person. People's needs were then re-assessed on admission to the home. The manager said she had found that information given beforehand is not always complete and informal carers do not always know the extent of a person's disabilities and care needs. In one recent case the care needs were found to differ in some respects from the assessment that had been carried out by health and social care workers before admission. Further guidance and support was being sought so that suitable care could be provided at the home.

We observed during this visit that the home worked regularly with other health care providers. Appointments for opticians, dentists, physiotherapists, community psychiatric nurses, continence nurses and occupational therapists were booked or discussed during the day. We saw that staff and management were active in seeking support and treatment on behalf of people living at the home.

Our judgement
People's health, safety and welfare was protected when more than one provider was involved in their care and treatment. This was because the provider worked in co-

operation with others.

The provider was meeting this standard.

Outcome 07:
Safeguarding people who use services from abuse

What the outcome says

This is what people who use services should expect.

People who use services:
* Are protected from abuse, or the risk of abuse, and their human rights are respected and upheld.

What we found

Our judgement

The provider is compliant with Outcome 07: Safeguarding people who use services from abuse

Our findings

What people who use the service experienced and told us
We spoke to people who lived in the home but their feedback did not relate to this standard.

Other evidence
Information from the Devon County Council Care Direct service about safeguarding adults was displayed in a communal area, to help people identify abuse and guide them as to who they should contact if they had concerns.

We saw that staff training on the protection of vulnerable adults was booked for the following month. Staff confirmed that they had received training previously, and this was to update their understanding. They understood what practices constituted abuse and that they had a duty to report concerns or allegations so that the correct action would be taken.

During the previous year the manager had taken appropriate action when poor practice and abuse came to her notice. An alert was sent to the Devon County Council safeguarding team and disciplinary action was taken.

Staff told us that the manager and provider were both approachable, and they had no hesitation of taking any concerns to them, with confidence that appropriate action would be taken.

Our judgement

People who use the service were protected from the risk of abuse, because the provider had taken reasonable steps to identify the possibility of abuse and prevent it from happening.

The provider was meeting this standard.

Outcome 09:
Management of medicines

What the outcome says

This is what people who use services should expect.

People who use services:
* Will have their medicines at the times they need them, and in a safe way.
* Wherever possible will have information about the medicine being prescribed made available to them or others acting on their behalf.

What we found

Our judgement

The provider is non-compliant with Outcome 09: Management of medicines. We have judged that this has a moderate impact on people who use the service.

Our findings

What people who use the service experienced and told us
We spoke to people who lived in the home but their feedback did not relate to this standard.

Other evidence
Our inspection of July 2009 found that medicine storage was unsafe. Since then a separate locked fridge had been installed to store any medication that required refrigeration. The manager told us that its temperature was checked and recorded by staff each day so they could be sure that medicines were kept within the safe range recommended by the manufacturer.

A new steel medication cabinet had been fitted to a solid wall, with a controlled medication cabinet secured within, also fixed suitably to the wall in accordance with regulations so that people can be assured their medicines are kept secure.

Most medication was supplied to the home in a monitored dosage system, with the medication put into 'blister packs' by the pharmacy. A number of drugs that were not suitable for such packaging were supplied in boxes, bottles and sachets.
At Heron's Lea, staff transferred medication from this original pharmacy supplied and labelled container and placed them into another container for later administration. The manager said they found this method practical and they managed to deliver medications in a timely way in spite of the fact that the home was on two floors, had no passenger lift, it was not possible to take a trolley round, and people did not all stay in

their room to receive their medication. This system, known as 'potting up', is an outdated and unsafe practice which puts people at risk of receiving an incorrect dose of medication. This practice had been evaluated by professional bodies over a long period and found not to be acceptable.

Our judgement
Safe storage facilities had been provided for medication.
The registered person had not made an appropriate arrangement for the safe administration of medicines as medicines were not administered directly to people from the labelled containers provided by the pharmacy.

The provider was not meeting this standard. We judged that this had a moderate impact on people using the service and action was needed for this essential standard. This is a breach of Regulation 13 of the Health and Social Care Act 2008.

Outcome 14:
Supporting staff

What the outcome says

This is what people who use services should expect.

People who use services:
* Are safe and their health and welfare needs are met by competent staff.

What we found

Our judgement

The provider is compliant with Outcome 14: Supporting staff

Our findings

What people who use the service experienced and told us
We spoke to people who lived in the home but their feedback did not relate to this standard.

Other evidence
The manager provided a training matrix showing the training that staff had received. It showed that there was a good provision of the essential training that was needed to enable staff to deliver care in a safe and suitable way.
We saw on the staff notice board that training in fire safety had been booked for later in the month. There was also a notice about a training day for all staff, which was to cover infection control, food hygiene, moving and handling and the protection of vulnerable adults. This showed that staff knowledge of vital subjects was being kept up to date.
Staff told us they had received training in the administration of medication. The manager told us that an introduction to awareness of dementia was included for staff in their initial induction and they used information and resources from specialist web sites. Some staff had attended training on end of life care as the home was supporting people at the end of their lives with support from District Nurses.

The provider may find it useful to note that staff would benefit from further training about specific care needs of people living in the home, which could include behaviours that challenge and health conditions including diabetes and epilepsy, and more advanced training in dementia care.

Appointments for all staff to meet with their manager for their 1:1 discussion were posted on the staff notice board. Staff confirmed that they had met at approximately

three monthly intervals. The manager kept a supervision file. It included guidance for staff on what was expected of them, covering person centred approaches and risk assessment, the role of the worker, maintaining safety.
A supervision contract had been introduced and a supervision record was regularly used. We looked at a small sample and saw they included assessment of performance with evidence and agreed action, so that the manager and staff could evaluate their performance and consider training needs and aspirations for continuous development as well as facing up to any shortfalls. Two staff were seeking to advance their training. This demonstrated a good attitude towards training in the home from staff who were keen to improve their practice.

Our judgement
Staff received appropriate professional support and development.

The provider was meeting this standard.

Outcome 16:
Assessing and monitoring the quality of service provision

What the outcome says

This is what people who use services should expect.

People who use services:
* Benefit from safe quality care, treatment and support, due to effective decision making and the management of risks to their health, welfare and safety.

What we found

Our judgement

The provider is compliant with Outcome 16: Assessing and monitoring the quality of service provision

Our findings

What people who use the service experienced and told us
We spoke to people who lived in the home but their feedback did not relate to this standard.

Other evidence
A satisfaction survey had been carried out giving people who live in the home and their relatives an opportunity to express their views. There had not yet been an evaluation or summary to share the findings.

Accidents and incidents had been recorded. The provider may find it useful to note that an analysis of these could lead to a better understanding of contributory factors and help them make risk assessments more effective.

We saw that the manager carried out a number of regular checks, that included care planning, medication, and health and safety. She walked around the home each day to complete a health and safety checklist that included watching out for the safe use of wheelchairs and domestic equipment. We noticed that a fire door was not adjusted safely. She informed us that the provider had decided to install a new fire door system, which shows that management were working to maintain a safe service.

Our judgement
The provider had an effective system in place to identify, assess and manage risks to the health, safety and welfare of people using the service.

The provider was meeting this standard.

Action
we have asked the provider to take

Compliance actions

The table below shows the essential standards of quality and safety that **are not being met**. Action must be taken to achieve compliance.

Regulated activity	Regulation	Outcome
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 09: Management of medicines
	How the regulation is not being met: The registered person had not made an appropriate arrangement for the safe administration of medicines as medicines were not administered directly to people from the labelled containers provided by the pharmacy.	

The provider must send CQC a report that says what action they are going to take to achieve compliance with these essential standards.

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's report should be sent to us within 28 days of the date that the final review of compliance report is sent to them.

Where a provider has already sent us a report about any of the above compliance actions, they do not need to include them in any new report sent to us after this review of compliance.

CQC should be informed in writing when these compliance actions are complete.

What is a review of compliance?

By law, providers of certain adult social care and health care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The Care Quality Commission (CQC) has written guidance about what people who use services should experience when providers are meeting essential standards, called *Guidance about compliance: Essential standards of quality and safety*.

CQC licenses services if they meet essential standards and will constantly monitor whether they continue to do so. We formally review services when we receive information that is of concern and as a result decide we need to check whether a service is still meeting one or more of the essential standards. We also formally review them at least every two years to check whether a service is meeting all of the essential standards in each of their locations. Our reviews include checking all available information and intelligence we hold about a provider. We may seek further information by contacting people who use services, public representative groups and organisations such as other regulators. We may also ask for further information from the provider and carry out a visit with direct observations of care.

Where we judge that providers are not meeting essential standards, we may set compliance actions or take enforcement action:

Compliance actions: These are actions a provider must take so that they **achieve** compliance with the essential standards. We ask them to send us a report that says what they will do to make sure they comply. We monitor the implementation of action plans in these reports and, if necessary, take further action to make sure that essential standards are met.

Enforcement action: These are actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers are set out in the law and mean that we can take swift, targeted action where services are failing people.

Information for the reader

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