Inspection Report

We are the regulator: *Our job is to check whether hospitals, care homes and care services are meeting essential standards.*

Heath House

Elstree Road, Bushey, WD23 1GH

Tel: 02089010900

Date of Inspections: 16 July 2013
15 July 2013

Date of Publication: August 2013

We inspected the following standards as part of a routine inspection. This is what we found:

Respecting and involving people who use services	✓ Met this standard
Care and welfare of people who use services	✗ Action needed
Meeting nutritional needs	✗ Action needed
Staffing	✗ Action needed
Complaints	✓ Met this standard

Details about this location

Registered Provider	Quantum Care Limited
Registered Manager	Miss Ionie Pusey
Overview of the service	Heath House provides accommodation for up to 62 people with residential and dementia needs. It does not provide nursing.
Type of service	Care home service without nursing
Regulated activities	Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury

Contents

When you read this report, you may find it useful to read the sections towards the back called 'About CQC inspections' and 'How we define our judgements'.

Summary of this inspection

Why we carried out this inspection

This was a routine inspection to check that essential standards of quality and safety referred to on the front page were being met. We sometimes describe this as a scheduled inspection.

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 15 July 2013 and 16 July 2013, observed how people were being cared for and talked with people who use the service. We talked with staff.

What people told us and what we found

People we spoke with felt that their privacy and dignity was respected by staff and that there were enough activities provided by the home.

Care plans were not always fit for purpose as they required updating and did not always provide staff with information on how to care for people. Not all people were given call bells to alert the staff if they needed help or assistance.

Action was not always taken where people were at risk of dehydration. People were not always given the opportunity to have their preferred meals and were not involved in the planning of the menu. People were served food that was too hot placing them at risk of burns.

There was not enough staff on duty to meet the needs of some people who used the service.

The home had a complaints policy and procedure in place.

You can see our judgements on the front page of this report.

What we have told the provider to do

We have asked the provider to send us a report by 22 August 2013, setting out the action they will take to meet the standards. We will check to make sure that this action is taken.

Where providers are not meeting essential standards, we have a range of enforcement powers we can use to protect the health, safety and welfare of people who use this service (and others, where appropriate). When we propose to take enforcement action, our decision is open to challenge by the provider through a variety of internal and external appeal processes. We will publish a further report on any action we take.

More information about the provider

Please see our website www.cqc.org.uk for more information, including our most recent judgements against the essential standards. You can contact us using the telephone number on the back of the report if you have additional questions.

There is a glossary at the back of this report which has definitions for words and phrases we use in the report.

Our judgements for each standard inspected

Respecting and involving people who use services ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

People's privacy, dignity and independence were respected.

Reasons for our judgement

People we spoke with told us that staff were always respectful and protected their dignity whilst attending to or assist them with their personal care by ensuring that the bedroom door was shut and asked permission to assist them.
On the second day of our inspection we saw that approximately 30 people had attended a church service which was held at the home. We were told by the manager that peoples religious needs were documented in their care plan and that people were asked if they wanted to be informed and/or take part in religious celebrations. We saw evidence of this in peoples cares plans.

We saw that the home had a weekly activity chart outside the main lounge. People we spoke with told us that they were encouraged to join in activities and when necessary they were supported to participate. People also told us that if they choose not to participate their decision had been respected by staff.

Care and welfare of people who use services ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

Some people were not given call bells to request assistance or help and care plans were not always fit for purpose.

We have judged that this has a moderate impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

We spoke with five people who used the service and all were happy with the service they had received. They generally felt that staff were kind and attentive. One person told us that staff did not always respond to the call bell in an appropriate time frame. They felt this was because there was not enough staff.

During our tour of the home we walked around all four units. We noted that some people did not have a call bell in their bedroom. We also noted that some people's call bells were not situated in a position which was accessible to them for example we found some call bells behind the bed, or in an unreachable position.

The residents residing in the Windsor and Osborne units were living with advance dementia. Both units had the capacity to house up to 16 people. We saw that 11 occupied bedrooms on the Windsor unit and ten occupied bedrooms on the Osborne unit did not have access to a call bell and one bedroom on the Osborne unit, the call bell was situated behind the bed, therefore not accessible.

The residents residing in the High grove unit and Clarence unit had onset dementia and/or early stage dementia. Both units had the capacity to house up to 16 residents. We saw that four occupied bedrooms on the High grove unit and four occupied bedrooms in the Clarence unit did not have access to a call bell and one occupied bedroom in High grove unit, the call bell was not accessible for the resident.

This meant that call bells were not available or accessible for some people should they need to call for help or assistance.

We spoke with the manager about this; we were told that there may be a documented reason within people's care plan as to why they had not been given access to a call bell. We checked the care plans relating to the people who did not have access to a call bell and we were not able to find any explanation as to why. The manager told us that they would immediately order call bells and/or sensor mats for all residents.

We looked at 27 care plans across all four units. We found that the majority of care plans we looked at required updating and had missing or out of date information such as how many carers were needed to assist a person and some care plans were not signed. We also found that although the care plan stated what support people needed it did not always tell staff how to support people. We spoke with the manager about this. We were shown evidence that the manager had already undertaken audits on some care plans in June and July 2013 and had found that care plans were not up to the required standard. As a result an action plan was put in place to remedy this.
We looked at the audit in detail and noted that although issues had been found and managers of the respective units were asked to address the issues, they were not always given a deadline as to when they must address the issues by. This was discussed with the manager and the acting regional manager, who agreed to add deadlines to the audits. We noted that some audits were not signed or dated by the author.

We also looked at the 'turning charts, of two people who were bed bound covering the period 26 June – 14 July 2013. Both charts instructed staff to change the relevant person's position every two hours. We noted that either this had not been carried out every two hours of had not been noted. We spoke with the manager about this and we were told that they had recently spoken with staff about the gaps in the turning chart. They were told by staff that they had not recorded when a person was asleep and they had not changed their position as they appeared comfortable. The manager stated that staff were instructed to document when people were asleep and not turned. We saw that this was not always done.

The provider may wish to note that all care plans may need to be reviewed to ensure that they provide current and relevant information that meets people's needs.

Meeting nutritional needs ✖ Action needed

Food and drink should meet people's individual dietary needs

Our judgement

The provider was not meeting this standard.

Action was not always taken where people were at risk of dehydration. People were not always given the opportunity to have their preferred meals and were not involved in the planning of the menu. People were served food that was too hot placing them at risk of burns.

We have judged that this has a moderate impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

People we spoke with described the food as 'good' 'adequate' and 'ok'. People said that they always had enough food to eat, but did not always like what was being serve. People said that the home often provided an alternative meal like sandwiches if they did not like the food served that day.

We looked at people's fluid charts we saw that there daily intake of fluid was recorded. However, where people had not had the required amount of fluid we were not able to see where the unit managers had recorded any action taken. We spoke with the manager and acting regional manager about this and we were told that the unit managers checked people's fluid charts daily but did not record that they had checked the charts. We were told that the home would put measures in place to ensure that if people did not have the required amount of daily fluids the unit manager would record a reason or any action taken.

We observed lunch time on the advance dementia unit. Meals were served to people once they were comfortably seated at the table. We saw that people were offered drinks throughout the mealtime. We noted that people who were on pureed diets and needed assistance were fed at their own pace by staff who sat with them.

We noted that a person who was sat near the two members of staff who were serving the food was having difficulty cutting and eating their food. This went unnoticed by staff for ten minutes. We then advised staff that the person needed assistance. A member of staff asked the person if they required help to eat their food. The person stated that they did.

We observed that the staff member who assisted the person had left the person on two occasions to attend to other people. On the first occasion the person was left for 10 minutes on the second occasion the person was left for 12 minutes. The staff member did not provide the person with an explanation, but instead left the person, who in turn struggled to cut their food and attempted to eat the food without success. Upon the staff

member returning they apologised to the person. This meant that staff did not support the person to meet their eating needs with sensitively and respect for their dignity and ability.

We observed a member of staff serving pudding (apple tart and custard) to three people. We heard the member of staff tell the three people that the custard was very hot and that they should be careful. We noted that those people immediately tried to eat the custard and all shouted 'it's too hot'. This was said several times by people and no staff member in the room responded. The member of staff returned to the serving station. We then observed the custard and could visually see the steam leaving the custard. The member of staff attempted to serve other people with the extremely hot custard. We advised the member of staff that the custard was far too hot to give to people and that they should wait until it cooled down. This meant that staff had not taken reasonable precaution to ensure that the pudding was at a reasonable temperature before serving to people.

We later spoke with the chef manager and we were told that staff were always told to remove custard and rice pudding from the serving tray in order to allow it to cool down before serving it to people. We were told by the chef manager that a dummy menu was drafted at the chef managers meeting and then a decision is made by the head office as to what the actual menu would be. We asked what input was taken from the residents prior to the menu being made. We were told that people were not involved in the decision making of the menu. We asked if the head office was aware of people's dietary needs. We were told that they were not. We asked if people were asked by the head office to comment on the food that they received. We were told that this was done in the annual survey. We asked the manager and acting regional manager why the menu was done by the head office, we were told that it was to ensure that people had a balanced diet.

We looked at the menu over a four week period and we could see that the chef manager had made changes to the menu. We noted that salad and fresh vegetables were served every day. The chef manager told us that they had to often changed the menu as they knew that some food choices on the menu prepared by the head office were not what people in the home would eat.

Staffing ✖ Action needed

There should be enough members of staff to keep people safe and meet their health and welfare needs

Our judgement

The provider was not meeting this standard.

There was not enough staff on duty to meet the needs of people.

We have judged that this has a moderate impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

We spoke with the manager about the needs of the people who used the service. We were told that of the 14 residences in the high grove unit four people who required help would need two staff members each time to assist them. The Osborne unit also had 16 residences of which six people required assistants from two staff members and of the Windsor unit, 5 of the 16 people required two members of staff to assist them.

We were told that those three units each had three carers in the morning and afternoon with one floor manager in the morning and afternoon, who covered all the units. At night there was one carer on each unit, with one floor manager who covered all the units. Records reviewed showed evidence of this.

The staffing level meant that people who required two staff to assist them may have had to wait for long periods of time before staff could assist them with personal care, re-positioning, moving around the home and/or getting washed and dressed. Some staff we spoke with felt that there was not enough staff on duty on some units to meet the needs of people.

We were told by the manager and acting regional manager that the home had recently reviewed their staffing levels as they had found that people needs had changed and that more staff were required. As a result additional day staff were placed on each unit. We were told that the provider was in the process of reviewing the staffing level at night.

Complaints ✓ Met this standard

People should have their complaints listened to and acted on properly

Our judgement

The provider was meeting this standard.

There was an effective complaints system available.

Reasons for our judgement

The home had a complaints policy and procedure in place. We saw that the home had received one complaint in the last year. This had been appropriately recorded and responded to within a reasonable time scale. We saw that the complaints form also asked people to make suggestions about possible improvements to the home.

The manager told us that the home also had a 'grumble sheet' this was used for relatives and/or people who used the service who did not want to make a complaint but wanted to bring an issue to the attention of the manager. We saw that the home had received several complimentary letters and cards from relatives and friends of people who had used the service in the last 12 months.

This section is primarily information for the provider

Action we have told the provider to take

Compliance actions

The table below shows the essential standards of quality and safety that **were not being met**. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activities	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	**Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010** **Care and welfare of people who use services** **How the regulation was not being met:** Some people were not given call bells to request assistance or help and care plans were not always fit for purpose.
Regulated activities	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	**Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010** **Meeting nutritional needs** **How the regulation was not being met:** Action was not always taken where people were at risk of dehydration. People were not always given the opportunity to have their preferred meals and were not involved in the planning of the menu. People were served food that was too hot placing them at risk of burns.
Regulated activities	Regulation
Accommodation for persons who require	**Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010**

This section is primarily information for the provider

nursing or personal care Treatment of disease, disorder or injury	**Staffing** **How the regulation was not being met:** There was not enough staff on duty to meet the needs of people.

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 by 22 August 2013.

CQC should be informed when compliance actions are complete.

We will check to make sure that action has been taken to meet the standards and will report on our judgements.

About CQC inspections

We are the regulator of health and social care in England.

All providers of regulated health and social 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 essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as "government standards".

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of other services less often. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service's records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.

How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

✓ **Met this standard**	This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.
✖ **Action needed**	This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.
✖ **Enforcement action taken**	If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.

How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. Only where there is non compliance with one or more of Regulations 9-24 of the Regulated Activity Regulations, will our report include a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation). This could be a minor, moderate or major impact.

Minor impact - 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.

Moderate impact - 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.

Major impact - 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

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.

Glossary of terms we use in this report

Essential standard

The essential standards of quality and safety are described in our *Guidance about compliance: Essential standards of quality and safety*. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the *Guidance about compliance*. The 16 essential standards are:

Respecting and involving people who use services - Outcome 1 (Regulation 17)
Consent to care and treatment - Outcome 2 (Regulation 18)
Care and welfare of people who use services - Outcome 4 (Regulation 9)
Meeting Nutritional Needs - Outcome 5 (Regulation 14)
Cooperating with other providers - Outcome 6 (Regulation 24)
Safeguarding people who use services from abuse - Outcome 7 (Regulation 11)
Cleanliness and infection control - Outcome 8 (Regulation 12)
Management of medicines - Outcome 9 (Regulation 13)
Safety and suitability of premises - Outcome 10 (Regulation 15)
Safety, availability and suitability of equipment - Outcome 11 (Regulation 16)
Requirements relating to workers - Outcome 12 (Regulation 21)
Staffing - Outcome 13 (Regulation 22)
Supporting Staff - Outcome 14 (Regulation 23)
Assessing and monitoring the quality of service provision - Outcome 16 (Regulation 10)
Complaints - Outcome 17 (Regulation 19)
Records - Outcome 21 (Regulation 20)

Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.

Glossary of terms we use in this report (continued)

(Registered) Provider

There are several legal terms relating to the providers of services. These include registered person, service provider and registered manager. The term 'provider' means anyone with a legal responsibility for ensuring that the requirements of the law are carried out. On our website we often refer to providers as a 'service'.

Regulations

We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

Responsive inspection

This is carried out at any time in relation to identified concerns.

Routine inspection

This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.

Themed inspection

This is targeted to look at specific standards, sectors or types of care.

Contact us

Phone:	03000 616161
Email:	enquiries@cqc.org.uk
Write to us at:	Care Quality Commission Citygate Gallowgate Newcastle upon Tyne NE1 4PA
Website:	www.cqc.org.uk