Heathlands Care Home (Chingford) Ltd

Heathlands Care Home

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

Heathlands Care Home is a nursing home that provides care for up to 84 people. At the time of our inspection there were 77 people using the service.

The service had an acting manager who had been in place for three months at the time of our inspection. They were currently awaiting the outcome of their application to become the registered manager of the service. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The service was safe and people using the service communicated this to us. Staff demonstrated their knowledge in safeguarding adults and what action to take should they have any concerns. The service reported any accidents and incidents as well as safeguarding's to the relevant local authority and to the Care Quality Commission (CQC).

The service had robust risk assessments in place and people using the service were protected from harm where risks were identified. Risk assessments were thorough and contained clear mitigation plans.

Staffing levels were adequate for the level of need across the units and staff told us that any absences were covered. Staff were recruited safely and in line with relevant pre-employment checks.

People's medicines were managed, stored and administered safely and audits were completed to ensure consistency.

The service was effective and we saw that people received care based on best practice from staff who had the knowledge and skills through training and supervision to carry out their roles and responsibilities. Staff told us they were supported in their roles.

Consent to care and treatment was sought and we observed examples of this. Staff had an understanding of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS). The service monitored how consent was obtained and this was recorded accordingly.

People were supported to have sufficient amounts to eat and drink and maintain a balanced diet. People told us they enjoyed the food and that it was varied. People told us they had a choice of food and that they were made alternative meals if they didn't fancy what was on the menu. Dietary needs were adhered to and monitored where relevant.

People were supported to maintain good health and have access to on-going healthcare support. Referrals to healthcare professionals were prompt and records of people's health needs were documented. The

service had a good working relationship with the local CCG who provided on-going support to people using the service and management.

The service was caring and we observed positive caring relationships with staff and people using the service. People told us they were happy with their care. People were supported to express their views and be involved in making decisions about their care, treatment and support. People were given choice and independence was promoted. People's privacy and dignity was respected. People who were at the end of their lives and receiving palliative care were cared for in a dignified manner and had specific care plans in place.

The service was responsive and care planning was thorough and detailed. People's preferences, wishes and aspirations were identified and people were supported to follow their interests. Care plans were reviewed on a regular basis and changes were recorded accordingly.

Concerns and complaints were encouraged and responded to and people knew how to complain and share their experiences. Families were encouraged to provide feedback and relatives meetings were a regular occurrence. Management acted on the information they received about the quality of care provided and concerns and complaints were used as an opportunity to make improvements.

The service was well led and management promoted a positive culture that was open and inclusive of all staff. The service had links with the local community such as the church. The service demonstrated good visible leadership and the acting manager understood their responsibilities. Quality assurance practices were robust and records and data were collected and used to strive for improvements at the service. During the course of the inspection we found that CQC had not been sent notifications for people who had been authorised for DoLS. The manager promptly sent them through before the end of the inspection.

We found one breach of the Care Quality Commission (Registration) Regulations 2009 (Part 4). You can see what action we told the provider to take at the back of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe. People were protected from harm. Staff knew how to deal with any concerns and raise safeguarding's where necessary.

The service had robust risk assessments in place and mitigation plans were thorough.

Accidents and incidents were recorded and reported.

Staffing levels were adequate for the dependency of each unit and any absences were covered promptly.

Medicines were stored, administered and disposed of correctly and medication administration records were up to date.

Is the service effective?

Good

The service was effective. Staff received training and an induction upon commencement of their role. Staff received regular one to one support.

Consent to care and treatment was sought and staff understood the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

People were supported to have sufficient to eat and drink and they told us they enjoyed the food, which was varied.

People received on-going support from healthcare professionals and referrals were made quickly when health needs changed.

Is the service caring?

Good

The service was caring and relationships between staff and people using the service was kind and compassionate.

People were supported to make decisions and people were given choice in day to day aspects of their care.

Privacy, dignity and respect were promoted.

People who were at the end of their lives and receiving palliative care were cared for in a dignified manner.

Is the service responsive?

Good

The service was responsive. Care plans were personalised and specific to people's needs. They were reviewed regularly and any changes in people's needs were documented and acted upon.

The service had a vast array of activities on offer for people using the service and this also included daily one to one time for people who were cared for in bed.

Concerns and complaints were encouraged and responded to.

Is the service well-led?

Good

We found that the service had not submitted notifications to the CQC about the decisions of applications submitted for DoLS.

Staff spoke highly of the manager and felt supported in their role.

Team meetings took place on a regular basis. Relatives meetings also took place regularly and any comments or suggestions were documented and acted upon.

There were robust quality assurance practices taking place and the information collated from these were collated and used to make improvements for the service.

The service worked in partnership with other organisations in the local area.

Heathlands Care 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.

The inspection took place on the 27, 28 and 29 September 2016 and was unannounced. The inspection team consisted of two inspectors, a nursing dementia specialist, a palliative care specialist and an expert by experience, who had experience with older people with dementia. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service.

Before our inspection, we reviewed the information we held about the service. This included the last inspection report. We also contacted the local borough contracts and commissioning team that had placements at the home, the local Clinical Commissioning Group (CCG), Healthwatch and the local borough safeguarding team. 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. In preparing for this inspection we looked at the information we already held about the service. We found the provider had not sent us any statutory notifications for people authorised for Deprivation of Liberty Safeguards (DoLS).

During our inspection we observed care and support in communal areas and also looked at some people's bedrooms and bathrooms with their consent. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We spoke with 30 members of staff which included carers, nurses, the manager, deputy manager, administrative assistant, training manager, cook, facilities technician and activities coordinators. We spoke with 10 people using the service and two family members. We looked at 22 care plans and policies and procedures for the home.

Good

Is the service safe?

Our findings

One person using the service told us, "Yes I feel safe here. I've got a lovely room and people are very nice, it couldn't get better." Another person told us, "Yes I do feel looked after here. I've got people around me and the staff here are always on hand."

We saw that policies and procedures were in place for safeguarding and whistleblowing. Staff told us they had a good understanding of safeguarding. One member of staff told us about a person that came in to the home from hospital with a pressure ulcer and how a safeguarding referral was made to the local authority. The member of staff also told us, "If I suspect someone is being abused I will have to report it to my manager." When we asked what they would do if they suspected the manager of abuse they replied, "I would phone HR if it was the manager." The safeguarding policy clearly stated how to raise a safeguarding alert and who to contact. In addition, the whistleblowing procedure was clear in explaining who to contact in the relevant circumstances. One member of staff told us, "You have to speak to your line manager and the home manager and if it has not worked you can take it further."

Care plans included thorough risk assessments and we saw examples of these. One person was at high risk of falling out of their chair. There was a mitigation plan that stated, "Ensure that [person] is seated in the centre of the chair. A slide proof mat is to be placed on the recliner chair/wheelchair at all times. Chair to be kept clean and maintained." This meant that the service was aware of the risk and had plans in place to support people if the risk materialised.

One person had a support plan and risk assessment in place for the management of their behaviour, which included physical aggression at times. Staff told us they managed these behaviours well and one staff member said "We manage this by redirecting [person] to their room, making [person] a cup of tea and provide them with a cigarette because cigarette could be their trigger." We saw records of the behavioural support plan and staff adhered to the management strategies within it.
The service had robust staff recruitment procedures in place. Staff told us and records confirmed that various checks were carried out on people before they commenced working at the service. One staff member said, "I was called for interview. They did a DBS check and asked for my references." A DBS (Disclosure and Barring Service) check is a check carried out to see if prospective staff have any criminal convictions or are on any list that prevents them from working in a care setting. Records showed the service carried out various checks on staff including DBS checks, employment references, proof of identification and records of previous employment history. This meant the service had taken steps to help ensure staff were recruited that were suitable for the role.

One staff member told us that when they had a full complement of staff working on duty this was "Fine". However, they also said, "Most of the time we do have full staff, but not always. When we are short staffed it puts pressure and stress on staff." Staff told us that cover was arranged for absences and that although they were busy they felt they could do their job effectively with the staffing levels on each unit. We saw records of staff numbers by looking at the daily rotas and saw that there were six members of staff on each unit at all times, with one always being a registered nurse. The deputy manager told us staffing levels were, "By unit

dependency", and stated, "Each unit has sufficient staffing numbers. If someone is off sick we call around our own staff first before calling agency. On Thursdays during the GP round we always have an extra nurse on shift to support with this." The shift coordinator for one of the units told us, "Right now we have enough staff, there isn't a high absence level and if we have to, we will call agency but this is rare."

Staff were trained and assessed as competent before administering people's medicines. People had medicine records in place, which included a photograph of the person and their medical condition. We observed a medicine round and on one occasion a tablet fell to the floor and this was disposed of correctly and documented on the person's records. The medicine round adhered to the service's medication policy in terms of safe administration and a Medicine Administration Record (MAR) was completed for each person correctly with no unexplained gaps. Medicines were stored safely in a locked trolley in a locked room and the process of the disposal of drugs was followed safely. We checked the controlled drug cabinet and records which were stored securely within a locked cupboard. Records showed that two nurses signed when controlled drugs were dispensed. A spot check of one of the controlled drugs showed accurate recording with the correct amount of the drug still present. The controlled drug records were checked twice daily at handover and the process included a record of who held the drug keys for the shift. There was a process within the service's medicine policy for people who were self-medicating but at the time of our inspection we were informed that no patients were self-medicating.

People's records showed that PRN medicines were prescribed for those people who were nearing their end of life. PRN medicines are those which are given on a 'when needed' basis. The drugs were prescribed for the correct route and the right frequency and the qualified staff understood why they had been prescribed. The service supported people with their money and the administrative assistant had an audit system in place to ensure that people were receiving their money and that expenditure was practiced safely. They showed us financial records and receipts for people using the service and explained the process to us stating, "We will request money from head office and they will send it through. We make a record of the money received and send head office a receipt from the bank. Relatives come in all the time and give us money. We will enter this into the computer using specified software and ensure that it is shown on their records, for example if they go to the hairdresser they will get a receipt. All receipts are kept on file and everyone has their own financial record." We saw records of receipts and people's financial records and saw that all transactions were documented. The administrative assistant explained to us that it was essential to make sure people had access to their money and that this was done safely stating, "If someone comes in and asks for money, for example for their relative, it will depend on whether the resident has capacity and not whether the person asking has authority, for example if they have power of attorney. We have a copy the power of attorney documents so we can always check." This meant that the service was operating a robust system to ensure that people's finances were managed safely.

Accidents and incidents were recorded and staff told us they would record any incidents, inform the manager and advise staff at handover to keep them informed should extra support be given. We saw records to confirm this.

The premises were well maintained. The service employed a facilities technician who routinely completed a range of safety checks and audits such as fridge temperature checks, first aid, fire system and equipment tests, gas safety, portable appliance testing, electrical checks, water regulations and emergency lighting. The systems were robust, thorough and effective. The home environment was clean and we saw domestic staff throughout the inspection. The home was free of malodour.

Good

Is the service effective?

Our findings

The training manager told us that newly recruited staff that had not previously worked in a care setting were expected to complete the Care Certificate and we saw records of this. The Care Certificate is a staff induction training programme specifically designed for staff that are new to the care sector. New staff who had experience of working in care also undertook an induction which included training in first aid, moving and handling, Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS), health and safety, infection control, safeguarding adults and dementia care. One recently recruited staff member said of their induction, "I had to do training with [training manager]. I did health and safety, duty of care, role of the health care assistant and training on fire safety." New staff also worked at the service in a supernumerary capacity shadowing experienced staff members to learn how to provide support to individuals.

Staff told us they had access to regular on-going training. One staff member said, "Two or three weeks ago I had dementia training. They send you a text when you are due training. Another staff member said, "I've had loads of training, stoma, moving and handling, wound assessment." Another staff member said, "We get lots of training here." The service had a training matrix which detailed when staff had last undertaken training in each topic and when they were next due to have it. This showed that the vast majority of staff were up to date with training. Where staff missed a planned training session we saw letters on files advising them that they were required to take the training. The training manager told us that much of the training was mandatory for all staff and this included training on moving and handling, fire safety, first aid, safeguarding adults, dementia care and food hygiene. In addition, other training was provided to staff depending on their role, such as catheter care training for nurses and palliative care training. Staff told us over the last few months the training they had received and been responsive to their needs and they felt their knowledge around palliative care had increased. The clinical lead of the palliative care unit had recently been on a three day course at a local hospice and she felt this had enhanced the level of care she was able to give to people. A further 10 members of staff had recently completed a one day Introduction in palliative care. This meant the service supported staff to develop, learn and keep up to date with skills and knowledge required for their role.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS).

We found the service had up to date policies and procedures in relation to the MCA so that staff were provided with information on how to apply the principles when providing care to people using the service and we were made aware of people subject to DoLS authorisations. We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. At the time of inspection people who used the service had authorised DoLS

in place because they needed a level of supervision that may have amounted to a deprivation of liberty. The service had completed appropriate assessments in partnership with the local authority and any restriction on people's liberty was within the legal framework.

Consent to treatment was captured in people's notes and for those people who lacked capacity, family members who had power of attorney gave consent and this was documented in peoples care plans. During our inspection we observed care staff asking for consent and we saw a member of staff asking before repositioning someone.
DNAR (Do not attempt resuscitation) documentation were present in people's care plans. The DNAR's were signed and dated with completed 3 monthly review dates.
The manager told us they took over responsibility for managing the service in July 2016. They told us that at that time they identified there had been a problem with staff supervision and that most staff were not receiving a formal one to one supervision up to that time. They told us they had prioritised making sure that staff started to have regular supervision. Records showed that since the beginning of July 2016 virtually all staff had received at least one supervision and most staff had received two. The manager told us they planned to ensure that all staff received supervision at a minimum of three monthly intervals. Records of supervision evidenced discussions about performance, teamwork and issues affecting people who used the service. One staff member said of their recent supervision, "We talked about the training I had, if I needed support in anything, we discussed any issues with her [supervisor]."

We observed the lunchtime period on one of the units. People were seen to be enjoying the meal which was eaten at a relaxed pace. We saw people that required support with eating were done so in a sensitive manner. Staff were at the same physical level as the person and went at their pace. People were offered a choice of meals, all of which appeared appetizing and nutritious. We saw that staff offered people a choice of drink with their meals. The service had a four week rolling menu. Most of the foods on the menu reflected the cultural backgrounds of people using the service. The menu showed that people were offered up to three cooked meals a day including a cooked breakfast if required. The main meal was at lunchtime and there were three daily options, one of which was always vegetarian. The head chef told us that people were able to request meals that were not on the menu and we saw that one person had vegetable pasta and another had ham sandwiches for lunch, neither of which were on the menu. Each day people were asked which of the meal options they preferred and we saw records of this. One person using the service told us, "Yes, you get a good choice (of food). I'm not fussy but I do like my egg and chips and they'll make it for me if I ask." The head chef had a good understanding of people's dietary requirements. Two people had dietary requirements linked to their religion which was catered for. Other people had dietary requirements linked to diabetes and there was a list of those people in the kitchen. Some people needed their food pureed and we saw that where this was the case each different element of the meal was pureed separately which meant people were able to enjoy the individual tastes and flavours.

Risk assessments were in place around nutrition and hydration and staff had a good understanding of these. We saw that people's weight was checked monthly so the service was able to monitor if there were any significant weight gains or losses that may have indicated a health issue. The service worked with health professionals to help ensure people's safety with regard to nutrition. For example, one person was at risk of choking when eating and the service had worked with the speech and language therapy team to devise guidelines to support the person to eat safely. There was evidence of the use of the Malnutrition Universal Screening Tool (MUST) form and we saw documentation of referrals to a dietician where relevant. We saw that wound assessments included photographic evidence, including consent of the person to enable this practice to take place. We saw that people had been referred to a tissue viability nurse who had prescribed a care plan and there was evidence that this had been followed.

The service had good external links with the specialist palliative care team in the community. Staff told us that they felt they had made good external links with the specialist palliative care services and would seek help when needed. We found there to be additional good links with other external services such as the tissue viability nurses when patients had pressure sores. We also saw a patient who had dysphagia and a referral had been made to the community dietician. Dysphagia is difficulty or discomfort in swallowing. The advice that was given was captured in the person's care plan.

Good

Is the service caring?

Our findings

During our inspection we observed how positive and caring relationships were developed between staff and people using the service. For example, we observed a carer talking to a person with dementia who was exhibiting some confusion about how old he was and whether his parents would be visiting him that day. The carer spoke to him in a reassuring tone and told him that his wife would most likely be visiting him. When he told her he was not able to remember what his wife looked like, she described her to him and offered to show him some photographs of his wife, to which he responded positively to. He then said to the carer, "Everyone here should be thankful for you," to which she responded, "That's ok, it's my job." This interaction demonstrated an empathetic and patient attitude towards the person using the service and we consistently observed this kind of care throughout our inspection.

Another example of caring relationships between staff and people using the service was at lunch time, when we observed people being fed. A member of staff who was feeding a person did so in a dignified manner by sitting at their level and making conversation throughout, even though the person was not very communicative. For example, the staff member told the person their hair looked nice and asked whether they had visited the hairdresser, to which they answered, "Yes", they also talked about the sunny weather and how it was, "A good day to hang some washing out", to which the person smiled and nodded. The member of staff said, "You tell me when you've had enough to eat and if you fancy it I will get you some dessert", to which the person said, "Thank you, I'd like that." The interaction was happy and positive and the member of staff keen to ensure people received dignified and personalised care. They told us, "I love working with these people, you have to take the time and make the effort with conversation to and try to make everything as homely as possible. This showed that kindness and compassion were at the forefront of care.

Staff told us that they promoted people's dignity when carrying out personal care. One member of staff told us, "Even before entering the room you have to knock. If you are doing personal care you have to close the curtains and the door." Another member of staff explained, "I always shut the curtains, make sure I have everything ready and make sure I ask them whether they want their personal care." A third member of staff told us, "We make sure to cover people up when washing them. Make sure they are covered up when transferring between their bedroom and the bathroom." One person using the service told us, "Yes, they are respectful when they're washing me, they close the door and the curtains." During our inspection we saw examples of people's dignity being respected with a sign on people's doors saying 'care in progress'. We observed this was adhered to when we witnessed a member of staff knocking on a person's door but the person was on the commode and the member of staff was asked to come back later.

The service promoted people's independence. One member of staff told us, "You just assist them with things they can't do. If they can comb their hair you let them do it." Another member of staff said, "[Person] was washing his own cup one day and that's completely fine, we allowed him to do that. We don't treat him like a child just because he has dementia." We observed at meal times that people who could independently feed themselves were supported to do so. This meant that people were supported to be independent and not restricted from carrying out tasks autonomously.

One member of staff told us they, "Loved working on the unit with palliative care patients", and stated they cared for them in the way they would want to be cared for if they were in the same situation. Another member of staff explained how they handled a conversation when a palliative care patient asked them whether they were dying. The member of staff explained her interaction with the person stating that she reassured the person and told him, "Whatever was happening, you would be cared for".

A member of staff gave us an example about having gone the "extra mile" for someone. They told us they had recently taken a person who was receiving palliative care to their granddaughters wedding, as they knew how important this was for her. They told us it had been, "A pleasure to take them to the wedding."

Friends and relatives could visit freely without restriction and said they felt comfortable visiting at any time. We observed how visitors were greeted and welcomed by the service and time spent with family and friends were unrestricted.

Good

Is the service responsive?

Our findings

Care plans were in place and included comprehensive assessments of people's needs and how these could be met by staff. Staff told us the care plans were effective in helping them get to know individuals. One member of staff told us, "I looked through the care plans when I first started here and looked at people's likes and dislikes." We saw that care plans contained people's personal preferences, for example what name they would prefer to be referred to and what time they preferred to wake up in the morning. We saw that one person had stated that they liked the radio on at a specific time of day to listen to the news. Another person's preference record stated, "I like to go to bed around 10pm after either watching television or reading my book." Records reflected and we observed that this was happening. Care plans also contained people's life histories, for example their place of birth, jobs, whether they had any siblings and any significant childhood memories. One of the activities staff told us, "We have life histories for everyone and we have a life history project where we are making sure we know everyone's history. I make it my business to get to know them and we know the people here very well." We saw that part of the project was to create life history folders that included photographs and we were shown an example of one that had black and white wedding and family pictures with dates and commentary. These were used whenever people wanted to look at old photographs and during activities.

The activities coordinator showed us the various events that had taken place throughout the year. For example, we saw records and photographs of the Queens 90th birthday celebrations which consisted of a fete, entertainment, food and drink. One person using the service told us they enjoyed this event "Greatly." The activities coordinator told us, "Many relatives came to our celebration of the Queen's 90th birthday and we all had flags and a raffle. We had a really good time and it's something I'm really proud of." We also saw that there had been a casino afternoon, 'mojito Sunday' which consisted of a production by staff and a 'who done it' exercise. We saw that there had been an open mic afternoon, and a charity fundraiser coffee morning. All of these events were documented with photographs and kept in a photo album. The events coordinator told us they showed people using the service the photographs from time to time to refresh their memory, especially for those people with dementia. In addition, there were daily activities taking place which were organised by the activities coordinator and activities staff. The activities coordinator told us, "We have service user meetings where we ask people what they want to do and we go from there and incorporate it." We saw that there was an activities timetable that included one to one time with people using the service. The activities coordinator told us this was to, "Accommodate for those people who are cared for in bed, so we do room visits every day."

During our inspection we saw that one to one time was happening and people who were cared for in bed were given time with carers to talk, do light exercise and go into the garden and listen to music. There was a sensory room at the service and people were supported to access it and make use of the facilities. The activity coordinator told us how they strived to incorporate activities into people's day to day lives stating, "We look into their care plan and read their preferences, that usually tells us what they like and don't like. We use the Pool Activity Level (PAL) instrument which occupational health came and trained us on and we have a PAL plan for every person here." The PAL instrument is used as the framework for providing activity-based care for people with cognitive impairments, including dementia.

Resident's meetings took place on a monthly basis and we saw records of these. Discussions at these meetings included activities, outings and food. We saw a record where one person said, "I enjoy most activities especially the exercise, however the activity I enjoy the most is outings and going on lunch outings." The activities coordinator told us the service had a mini bus and they used this for taking people out. We saw records that people were taken to the pub, art gallery and tea room. The activities coordinator told us, "Even if the person has dementia we will still take them out. We will do a risk assessment on each resident and obtain consent from family when necessary." We saw examples of these assessments which were robust.

One person using the service told us, "I like doing the activities and exercises, playing cards and bingo and dominoes. I like watching TV in my room."
Records were kept of people's daily care needs and were documented once completed. This was in the form of a daily task checklist which was used as a communication tool between care staff to demonstrate if the care had been carried out. At the end of the shift the clinical lead would sign to confirm this care had been given and we saw that this was taking place. We found that those people who were palliative had advanced care plans in place, which documented their wishes.

Care plans were subject to monthly reviews and these were dated and signed when the review took place. For example we saw that one person had recently had a visit from a palliative care clinical nurse specialist and the review identified that the person no longer required specialist input. We saw that this was reflected in the care plan and there was a record of who to contact if the situation changed.

The service had a complaints policy that identified time frames for a response and contact numbers for external organisations. The service had their complaints procedure printed and displayed in public areas of the home, including the lifts. One person using the service told us, "I think if I had anything to complain about I'd tell the nurse first." The service kept a complaints log and we saw records of this. The complaints log meant that the service could keep track of when complaints were made and responded to in line with their policy and we saw that solutions were always provided in response letters, for example meetings were held with relatives.
The service kept a record of the compliments they had received and we saw examples of these. A recent letter from a relative of a person who had used the service stated, "Thanks to you all for the loving care you showed [relative] during his two month stay at Heathlands. You could not have been kinder, more loving or more diligent in your care for him." Another recent compliment stated, "Your devotion and support towards us all as a family has gone beyond measure. Thanks once again."

Good

Is the service well-led?

Our findings

We found that the service had not submitted notifications to the CQC about the decisions of applications submitted for DoLS. This meant that the CQC were unable to monitor that appropriate action had been taken. We spoke with the manager about this and they promptly sent us the notifications before the end of the inspection, however this was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009 (Part 4).

People told us they felt supported by the manager. One member of staff said, "I think she is very understanding. She makes the team work better. When you have an issue you can always go to her and she is very supportive." Another member of staff told us, "Honestly, she comes in, she doesn't get stressed out, and the place is run well because of both of them [manager and deputy manager]." They also told us, "When I first started I'd speak to the manager, she'd help me if I was stressed and I am definitely supported to progress in my career." The manager told us about the support they received and stated, "I've got fantastic support from the operational team."
Staff that we spoke to told us the clinical leads of the units were approachable and supportive. If there was something they were not clear about they would not hesitate to speak to them. One member of staff stated that she had regular meetings with her shift coordinator to see how she was getting on and if there were any issues that needed addressing and she felt it was a safe place to raise them. Another member of staff told us about the support they received from their shift coordinator stating, "Everyone is very happy with her. The whole shift runs perfectly."

The registered nurses from each of the units informed us that they held daily meetings with their colleagues in the same role. This was a practice that used to take place and for a number of reasons had been stopped but had now been reinstated, as it was valued. The purpose of the meetings were to share any issues, share information knowledge and ideas so each unit has an understanding as to what is going on so daily support can be offered.

We saw records that team meetings were taking place. For example we saw records of a team meeting for activities staff, night staff, domestic staff, head of departments and also a meeting for all staff. Discussions that took place were recorded and included care plans, activities, training, mobile phone use and welcoming new staff. Records showed that these respective meetings were taking place on a monthly basis. The manager told us, "We have a managers meeting every month and we have a theme, for example end of life". In addition, they told us, "We went to a conference in September 2016 and I took carers along with me and admin staff. It's nice to have care staff mixing with senior management."

We also saw records that relatives meetings were taking place on a monthly basis with the most recent in September 2016. Discussions included satisfaction with the service, staffing, food and activities. Records showed that the manager and deputy manager attended this meeting and that actions were taken when relatives raised concerns. For example, when a relative raised a question about the use of agency staff, it was documented that an explanation was provided by the manager. The manager told us that relative meetings took place in the evenings to give people who work during the day the opportunity to attend. We saw

posters on each of the units advertising the dates and times for forthcoming meetings. This meant that the service was striving to listen and give relatives the opportunity to express themselves and for management to action any suggestions for improvement.

We were shown records of a resident's satisfaction survey that was sent out in August 2016 and the manager told us that the feedback was collated and used for making improvements. Questions included, "How do you rate the quality of care?" and "How do you rate the friendliness of the staff?" One person's answers stated, "Fair" and "Good" respectively.

The service worked in partnership with organisations such as the local church and we saw records of feedback in relation to this stating, "We were delighted that [persons] were able to join us, on behalf of Heathlands Care Home .We were keen that the day reached out to the local community and we were very pleased that so many local organisations took part. It was especially great to have Heathlands represented." The manager told us that they had also built a good relationship with the local Clinical Commissioning Group (CCG). CCG's are clinically-led statutory NHS bodies responsible for the planning and commissioning of health care services for their local area. The local CCG had systematic contact with the manager and people using the service, which consisted of individual reviews and quality checks. For example the CCG carried out a full review of the service in August 2016 and produced a report which also set out recommendations and support for the service, examples included support with safeguarding's and training. This meant that the local CCG supported the service to provide high quality care for people with nursing needs.

The service had a robust audit system in place and we saw records of this. For example we saw that there had recently been an annual audit carried out by the provider which looked at aspects of the service, for example staff rotas, safeguarding referrals, falls analysis, referrals to health professionals and complaints. We also saw records of audits carried out by the manager and other senior members of staff. These included an audit of the use of call bells. This meant that the service could analyse who was using the call bell most frequently and whether there was a reason for this and how this could be managed. We saw that in relation to this audit, staff were going to have additional training in call bell usage and supporting the people who used it most frequently.

The manager told us and we saw records of unannounced night visits. For example we saw records that showed the manager visited the service at 5am and looked at whether any staff on duty were asleep, medicines charts were checked and it was documented whether there were any discrepancies in care. We saw records that these night checks were carried out on average three times in one month. The manager also told us about, "Daily 'walk the floor' quality monitoring", which consisted of a walk around the home to get an overview of how people using the service were, whether staff were dressed in uniforms and whether the units were free from odour. Records were made and we saw records of these observations. The manager was knowledgeable about people using the service and told us that the daily walks were a good way to get to know people. She also told us, "I will always go and work on the floor, I've got my uniform in the office, I am happy to do this, I am a registered nurse."
The administrative assistant for the service showed us the audits that they carried out which included checking the complaints log and making sure that all complaints were logged and responded to, checking the accident and incident logs and ensuring that follow ups were made, for example to a health professional or to the local authority. They also showed us their audits for safeguarding referrals which included recording when the referral was sent, the reason, the action taken, informing the next of kin and CQC.

There were policies and procedures in place to ensure staff had the appropriate guidance. The training manager told us they asked staff to sign off once they had read the policies and she kept a record of these so

that people who hadn't read them could be reminded. The policies and procedures were reviewed and up to date to ensure the information was current. We looked at a variety that included safeguarding, accidents and incidents, infection control, restraint and challenging behaviour.

The manager told us about their plans for the future of the service and presented to us with the operations manager their plans for electronic care plans and an electronic portal for relatives to access care plans and records. We were told that this electronic system was being trialled in a sister home and that it was, "Excellent for pulling governance and statistics and audits." They told us that these plans were also going to, "Have more time and interaction between staff and residents."
The manager told us they had an, "Open door policy" with staff and explained to us that they were in the process of applying to become the registered manager following a three month period as interim. They explained to us that they were, "Proud of all of the staff, they've had so much change and it has been rocky but they've rocked with me."

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 Registration Regulations 2009 Notifications of other incidents We found that the service had not submitted notifications to the CQC about the decisions of applications submitted for Deprivation of Liberty Safeguards. This meant that the CQC were unable to monitor that appropriate action had been taken. We spoke with the manager about this and they promptly sent us the notifications before the end of the inspection, however this was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009 (Part 4).