Heatherdale Healthcare Limited

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Inspection report

204 Hempstead Road
Hempstead
Gillingham
Kent
ME7 3QG

Tel: 01634260075

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 15 and 16 March 2016 and was unannounced.

Heatherdale Nursing Home provides accommodation for up to 40 people who need nursing and personal care. Communal areas, such as the lounge and dining room are on the ground floor. Bedrooms are over three floors accessed by stairs and a passenger lift. There is a garden to the rear of the building. At the time of our visit, there were 39 people who lived in the home. People had a variety of complex needs including dementia, physical health needs and mobility difficulties.

There was a registered manager at the home. 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.

Medicines were not being administered safely to all people living at the home. Clear and accurate medicines records were not maintained in all instances.
The registered manager had systems in place to manage safeguarding matters and make sure that safeguarding alerts were raised with other agencies. All of the people who were able to converse with us said that they felt safe in the home; and said that if they had any concerns they were confident these would be quickly addressed by the registered manager.

The home had risk assessments in place to identify risks that may be involved when meeting people's needs. The risk assessments showed ways that these risks could be reduced. Staff were aware of people's individual risks and were able to tell us about the arrangements in place to
manage these safely.

There were sufficient numbers of qualified, skilled and experienced staff to meet people's needs. Staff were not hurried or rushed and when people requested care or support, this was delivered quickly. The provider operated safe recruitment procedures.

Staff knew each person well and had a good knowledge of the needs of people who lived at the home. Training records showed that all staff had completed training in a range of areas that reflected their job role. Nurses were given training suitable for them to validate their ongoing registration as a nurse. Staff told us that they had received supervision and appraisals were on-going.

Where people lacked the mental capacity to make decisions the home was guided by the principles of the Mental Capacity Act 2005 to ensure any decisions were made in the person's best interests. We found the home to be meeting the requirements of Deprivation of Liberty Safeguards.

The food menus offered variety and choice. They provided people with nutritious and a well-balanced diet.

The cook prepared meals to meet people's specialist dietary needs.

People were involved in their care planning, and that staff supported people with health care appointments and visits from health care professionals. Care plans were amended immediately to show any changes, and care plans were routinely reviewed every month to check they were up to date.

People were treated with kindness. Staff were patient and encouraged people to do what they could for themselves, whilst allowing people time for the support they needed. Staff encouraged people to make their own choices and promoted their independence.

People knew who to talk to if they had a complaint. Complaints were managed in accordance with the provider's complaints policy.

People's needs were fully assessed with them before they moved to the home to make sure that the home could meet their needs. Assessments were reviewed with the person and their relatives. People were encouraged to take part in activities and leisure pursuits of their choice, and to go out into the community as they wished.

People spoke positively about the way the home was run. The management team and staff understood their respective roles and responsibilities. Staff told us that the registered manager and the deputy manager were very approachable and understanding.

There were effective systems in place to monitor and improve the quality of the service provided. We saw that various audits had been undertaken.
We found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. 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?

Requires Improvement

The service was not consistently safe.

People did not always receive the medicines they were prescribed.

Staff were knowledgeable in recognising signs of potential abuse.

Risks to people's wellbeing were understood and addressed in their care plans, or with representatives, where appropriate.

There were enough staff employed to ensure people received the care they needed and in a safe way.

There were effective recruitment procedures and practices in place and being followed.

Is the service effective?

Good

The service was effective.

Staff had the knowledge and skills to meet people's needs, and these were updated through attendance at training courses. Staff received supervision from their manager.

People's rights were protected under the Mental Capacity Act 2005 (MCA) and best interest decision made under the Deprivation of Liberty Safeguards (DoLS).

People were supported effectively with their health care needs.

People were provided with a choice of nutritious food.

Is the service caring?

Good

The service was responsive.

People's needs were fully assessed with them before they moved to the home to make sure that the staff could meet their needs.

The management team responded to people's needs quickly and appropriately whenever there were changes in people's need.

The provider had a complaints procedure and people told us they felt able to complain if they needed to.

Is the service responsive?

Good

The service was responsive.

People's needs were fully assessed with them before they moved to the home to make sure that the staff could meet their needs.

The management team responded to people's needs quickly and appropriately whenever there were changes in people's need.

The provider had a complaints procedure and people told us they felt able to complain if they needed to.

Is the service well-led?

Good

The service was well led.

The home had an open and approachable management team. Staff were supported to work in a transparent and supportive culture.

The provider had a clear set of vision and values, which were used in practice when caring for people.

There was a robust staffing structure in the home. Both management and staff understood their roles and responsibilities.

There were effective systems in place to monitor and improve the quality of the service provided.

Heatherdale Healthcare Limited

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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 25 and 31 May 2016 and was unannounced. The inspection was carried out by an inspector, specialist advisor and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, we looked at previous inspection reports and notifications about important events that had taken place in the home, which the provider is required to tell us by law. We used all this information to decide which areas to focus on during our inspection.

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We spoke with eight people, four relatives, six care staff, the activity coordinator, the kitchen manager, the clinical lead nurse, two other nurses, deputy manager and the registered manager. We also spoke with the provider who has an office at the home. We also spoke with one visiting healthcare professionals.
Most people were able to talk to us, but a few people who were living with dementia were not able to verbally communicate their views with us or answer our direct questions. We observed people's care and support in communal areas throughout our visit to help us understand the experiences for these people. We looked at the provider's records. These included six people's records, which included care plans, health care notes, risk assessments and daily records. We looked at four staff files, a sample of audits, satisfaction surveys, staff rotas, and policies and procedures. We also looked around the care home and the outside

spaces available to people.

This is the first inspection since the change in ownership.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe at the home. They said, "When I first came, I was anxious, but now I feel very comfortable here and yes, I feel safe here". Another person said "Yes, I do feel safe and secure here". Relatives felt their family members were safe in the home. One relative said, "Oh yes, she's definitely been safe here" Another relative said, "My Father is safe here. The care is good and I have no concerns".

People were not wholly protected from the risks associated with the administration of medicines. There were some issues found with medication recording. We found there were some gaps in the administration records, so it was not possible to tell if these people had received their medication as prescribed. The records for two people who receive Warfarin were unclear and provided confusing guidance. This had led to possible drug administration errors. This was discussed with the deputy manager who immediately put together a guidance pack and example MAR chart to ensure improved consistency in this regard. One person said that they had not received their prescribed pain relief medication for a number of days. This was investigated further on the day of the visit. It transpired that the pharmacy had repeatedly provided half the required amount of medication for a number of months. It was evident that the home had attempted to address this with the pharmacy and GP surgery. However, the home had not taken sufficient steps to ensure that the medication in question was procured. This meant that the person had gone for 4 days without their prescribed pain relief. Medicines only given when required (PRN) had protocols were in place instructing when this medicine can be given and what for.

Storage facilities were suitable for the needs of the service. Storage was neat and tidy and the rooms/fridges were kept at appropriate temperatures. Controlled drug records were examined and these corresponded with the stock on site in all but one case. A recording error had been made when transferring stock balances to a new Controlled Drug book. This error had not been identified despite a recent stock check.

The provider failed to manage medicines effectively and medicines were not being properly managed. This was a breach of Regulation 12 (1) (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Medication, records, storage and processes were examined during the course of the visit. Staff were observed administering medication on the ground floor and first floor. In both cases this was completed in a safe manner, by competent staff and in a person-centred way.

The home had medication policies and procedures in place which were up-to-date. Staff spoken to were knowledgeable about the medications they were administering and supported people to take their medication in a positive and appropriate manner. It was evident through discussion with the deputy manager that the home had worked hard to improve medication management processes since they took over the home.

The provider had taken reasonable steps to protect people from abuse. There were systems in place to make sure that safeguarding alerts were raised with other agencies, such as the local authority safeguarding

team, in a timely manner. Care staff told us they would tell the manager or deputy manager of any safeguarding issues.

Staff told us that they had received safeguarding training at induction and we saw from the training records that all staff had completed safeguarding training within the last two years. Staff were aware of the different types of abuse, what would constitute poor practice and what actions needed to be taken to report any suspicions of abuse that may occur. Staff told us the registered manager would respond appropriately to any concerns. Staff knew who to report to outside of the organisation and gave the example of CQC. Staff had access to the providers safeguarding policy as well as the local authority safeguarding policy, protocol and procedure. This policy is in place for all care providers within the Kent and Medway area, it provides guidance to staff and to managers about their responsibilities for reporting abuse. Staff told us that they felt confident in whistleblowing (telling someone) if they had any worries. The home had up to date safeguarding and whistleblowing policies in place. These policies clearly detailed the information and action staff should take, which was in line with expectations. This showed that the provider had systems and processes in place that ensured the protection of people from abuse.

Throughout the course of the visit the home appeared clean, hygienic and well-maintained. There were sufficient numbers of housekeeping staff on duty who were responsive to the needs of the service. Cleaning staff followed a schedule to ensure all areas of the home were attended to, but they were also seen to respond to spillages and accidents during the visit.

Care staff followed infection control procedures including frequent use of hand hygiene gels. Staff said that they had access to protective equipment when required and these were supplied in adequate amounts. Staff spoken to said that they had completed infection control and they understood the basic principles of universal precautions. We saw suitable posters in place reminding staff and people to wash their hands when using the toilet. Staff spoken with knew that the deputy manager was the infection control lead for the home.

Each person's care plan contained individual risk assessments in which risks to their safety were identified such as falls, mobility, diet, bed rails and skin integrity. Guidance about any action staff needed to take to make sure people were protected from harm was included in the risk assessments. This enabled staff to understand what was needed to help people to remain safe. People confirmed that the risk assessments had been discussed with them.

We spoke with both the deputy manager and the registered manager about how risks to people's safety and well-being were managed. They both were able to tell us how they put plans in place when a risk was identified. The deputy manager described the action they had taken to minimise the risk of falling for one person who had had a number of falls. This included using a special mat that connected to the call alarm system notified staff when the person had got out of bed for example. Staff were also aware of when they should be reminding people to use there walking aid to prevent them from falling. There was a clear plan in place which staff were aware of and used. Where people's needs changed, staff had updated risk assessments and changed how they supported people to make sure they were protected from harm. For example, where people were identified as at risk of developing pressure sores, specialist equipment such as pressure relieving mattress were in use.

Records of each referral to health professionals were maintained, for example, staff sought advice from the Speech and Language Team (SALT). We spoke with two members of staff who told us that they monitored people and checked their care plans regularly, to ensure that the support provided was relevant to the person's needs. The staff members were able to describe the needs of people at the home in detail, and we

found evidence in the people's support plans to confirm this. This meant that people at the home could be confident of receiving care and support from staff who knew their needs.

There were suitable numbers of staff to care for people safely and meet their needs. People we spoke with told us there were enough staff on duty during the day. A relative told us "There are always plenty of staff on duty". The registered manager showed us the staff duty rotas and explained how staff were allocated to each shift. The rotas showed there were more than sufficient staff on shift at all times. We also observed that there were sufficient staff on duty to meet people's needs, for example assisting people to eat their meals and helping people to get ready for activities. The registered manager said that if a member of staff telephones in sick, the staff in charge would contact their staff team to find cover if needed. This showed that arrangements were in place to ensure enough staff were made available at short notice. The registered manager told us that the roster is based on the needs of people, staffing levels were regularly assessed depending on people's needs and occupancy levels, and adjusted accordingly.

Safe recruitment processes were in place. Staff files contained all of the information required under Schedule 3 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Appropriate checks were undertaken and enhanced Disclosure and Barring Service (DBS) checks had been completed. The DBS checks ensured that people barred from working with certain groups such as vulnerable adults would be identified. A minimum of two references were sought and staff did not start working alone before all relevant checks had been completed. We saw that over and above these checks nurses pin numbers were check against the Nursing and Midwifery Council (NMC) data base. Staff we spoke with and the staff files that we viewed confirmed this. This meant people could be confident that they were cared for by staff who were safe to work with them.

Each person had an individual Personal Emergency Evacuation Plan (PEEP) in the grab bag prepared ready emergency evacuation. These are updated as people are admitted to the home they are also reviewed monthly to make sure the changes have been made.. The fire safety procedures had been reviewed and the fire log folder showed that the fire risk assessment was recently reviewed in 2016. Fire equipment was checked weekly and emergency lighting monthly. Fire drills took place monthly and those present people staff recorded. Staff spoken with understood what their responsibility would be in an emergency.

The design of the premises enhanced the levels of care that staff provided because it was specious, well decorated and had been suitably maintained. Corridors were spacious with good lighting which was crucial for helping a person with dementia and poor eye sight to make sense of their environment.

Good

Is the service effective?

Our findings

People said that staff looked after them well. One person said "The staff knows me well, they know how I like things and I never have to wait long when I need help". Another said "The nurses are very good, I get my medicines on time and they know when I am not feeling well and they look after me". A relative said, "Staff do contact us if needed. Generally they are very good and the way they look after mum is brilliant and they make sure she eats and drinks. I am so relieved she is here".

A healthcare professional commented as follows, "I have seen many improvements over the last months, nurses refer people when necessary and ask for advice from time to time. We are confident that they follow our instructions and they call us if there are any problems". One person told us "The staff are well trained and do a good job", others agreed. All staff completed training as part of their induction. New staff had provider's comprehensive induction records which they worked through during their probationary period. A new staff member said I have had lots of support from other staff at the home. I had not worked in a residential home before so although I had been a carer this was new to me. I have done lots of training and to start with I shadowed more experienced staff". Staff told us that they were supported to complete their induction and they had to show competency before their training was signed off. Staff were confident that by the end of their induction period they had attained the skills and knowledge to be able to care for the people living in the home. These skills were built upon with further training and on going support. Staff told us that their training had been planned and that they could request further specialist training if needed.

Staff were aware of their roles and responsibilities and had the skills, knowledge and experience to support people with their care needs. Staff had further specialised training such as caring for people with dementia. Nurses undertook the same training as the care staff, but also took further training in order to evidence validation of their nursing qualification. Some care staff had completed vocational qualifications in health and social care. These are work based awards that are achieved through assessment and training. To achieve a vocational qualification, candidates must prove that they have the competence to carry out their job to the required standard. This allowed management to ensure that all staff were working to the expected standards, caring for people effectively, and for staff to understand their roles and deliver care effectively to people at the expected standard. Staff received refresher training in a variety of topics, which included health and safety, fire safety, safeguarding and food hygiene. One member of staff told us "We are encouraged to do lots of training, our understanding of the training is talked about during supervision and if we are not sure about anything we can always ask" Staff knew the training was important as it helped them to meet people's needs. These included food and nutrition, moving and handling, and infection control. This showed that the registered manager regularly equipped staff with relevant skills and knowledge to effectively meet people's needs.

Staff told us they received opportunities to meet with their line manager to discuss their work and performance. A staff member said, "I had my supervisions with the deputy manager, it is now being booked in so we will have it regularly through the year." Another said "I am supported with my training and I have had supervision when we talk about if I need more training, I love working here". The registered manager confirmed supervisions were taking place although not regularly at first. However, now they are planned and

carried out regularly to make sure staff receive the required support". Records we viewed confirmed this.

Yearly appraisals have started in order to make sure these are spread out across the year. Development & training needs that were identified were being followed up with training being arranged. This means staff have the opportunity to improve their skills and knowledge ensuring effective delivery of care for people.

There were procedures in place and guidance was clear in relation to the Mental Capacity Act 2005 (MCA) that included steps that staff should take to comply with legal requirements. Guidance was included in the policy about how, when and by whom people's mental capacity should be assessed. Staff had attended Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) training. Staff evidenced that they had a good understanding of the MCA and DoLS. One staff member explained that every person has some capacity to make choices. They gave us examples of how they supported people who did not verbally communicate to make choices. Staff were able to describe how capacity was tested and how a person's capacity impacted on decisions. They could all describe how and why capacity was assessed, the statutory principles underpinning the MCA and related this to people that we were subject to DoLS. The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. Some of the people were currently subject to a DoLS. There were good systems in place to monitor and check the DoLS approvals to ensure that conditions were reviewed and met. The registered manager understood when an application should be made and how to submit one and was aware of a Supreme Court Judgement which widened and clarified the definition of a deprivation of liberty.

The home used a computer-based care planning system called Care Docs. We were told that this had not been in place for very long and staff were still getting used to the computerised system. The plans were accessible to staff and it was reported that there were enough computers to enable staff to complete their notes. Daily notes examined provided relatively basic information about food, hygiene and health needs, but could be more descriptive. Staff were made aware of this and these had improved by the second day of the inspection.

All the care files viewed had completed assessments such as skin integrity; nutrition and falls amongst other assessments. People's plans were normally reviewed monthly by staff. People assessed as at a higher risk of developing pressure ulcers had detailed plans in place, they provided descriptions of the actual care needed. For example, nutrition plans stated 'Consider the likes and dislikes' people's preferences had been recorded and we saw a copy of this inn the home's kitchen.
Records confirmed that there were systems in place to monitor people's health care needs, and to make referrals within a suitable time frame. The health records were up to date and contained suitably detailed information. Staff implemented the recommendations made by health professionals to promote people's health and wellbeing.
People and families had been asked to complete 'This is me' or 'Choices' sections with peoples care plans, this information was being added to the care files as it was received. There was information about people's social histories and backgrounds, the manager and her deputy had been undertaking in depth reviews with people and their families to improve the information they had on file and to make sure people were receiving their care in the way they preferred and met their care and support needs.

All staff spoken to were very knowledgeable about the people they supported. They had a good awareness of needs and risk factors and it was evident that positive and friendly relationships had been established throughout the home.

The risks to people from dehydration and malnutrition were assessed so they were supported to eat and drink enough to meet their needs. People who had been identified at risk had their fluid and food intakes

monitored and recorded. Staff responded to concerns about people's weight or fluid intake by seeking advice and additional support from people's general practitioner (GP), specialist nurses and dieticians. For example, a person was provided with a soft diet and staff helped them while eating to ensure risks of choking were reduced. Hot and cool beverages and snacks were offered to people by staff and upon request.

We received some very positive comments about the meals served in the home they included; "The food is very good, I have a choice. They come and tell me what's on tomorrow and if I don't like it they will do something else" and "I get drinks during the day and hot drinks at night". A relative said, "My mum is not a very good eater, but they seem to be coping with her and she has snacky bits". Another relative said "The food has improved. She used to have supplements, but now she eats the meals, they used to eat in the lounge. Now they all come in here (dining room) and it's so much better".

We observed lunch in the dining room where all the people were offered a choice. The food looked and smelt appetising and the portions were generous. Staff worked with the cook as team to ensure meals were delivered quickly and hot. Special requests and special dietary requirements were plated up separately. Other options were immediately available should anyone change their mind or want something not on the menu. There was a pleasant atmosphere in the dining room and it was evident that people enjoyed the food. The cook was aware of the dietary requirements of people and she was very actively involved in the delivery of the food and service. Diabetic desserts were available for those with diabetes. The cook told us that they provided variety of food and special needs/requests such as soft diet like pureed food and diabetic diet for diabetic people are taken care of. This showed that staff ensured people's specific nutritional needs were met.

People were accompanied to visit a dentist when necessary. A chiropodist visited the home every six to eight weeks and we saw their details amount information had provided their consent. People's appointments with healthcare professionals were booked, recorded and followed up by staff to ensure people attended and had effective care which followed the guidance of these professionals.

Good

Is the service caring?

Our findings

Almost all people and relatives spoken to said the care delivered was good and most thought the staff were friendly, kind, caring, attentive and respectful. "In my experience, the staff are nice and very good" and "I get a kiss and a cuddle in the morning which I look forward to". Other comments from people included; "Yes, I am aware of my care plan and I've had a review", "I do find they are respectful, they shut my curtains", "They do treat me with respect". Relatives were also pleased with the care at the home their comments included ""The care is marvellous", "They give them cuddles, the care staff must be a special breed, they (staff) are all angels".
Throughout the visit all staff were observed talking to people using the service in a positive and open manner. The home had a very welcoming atmosphere and staff were quick to respond to the needs of the people living there. Call bells were answered promptly and staff appeared unhurried. It was evident that staff had time to give 1:1 support and contribute to the social milieu of the home. Staff were respectful and ensured the dignity and privacy of people.

Healthcare professionals spoken with also confirmed that they found the home staff very friendly and caring. They said that there had been significant changes at the home and they were all positive. One commented "The staff are quick to call if they have any concerns about someone at the home, and they follow any requests we make regarding the care of residents in the home".

People were supported to make sure they were appropriately dressed and that their clothing was arranged to ensure their dignity. Staff were seen to support people with their personal care, taking them to their bedroom or the toilet/bathroom if chosen.

Staff provided clear explanations to people before they intervened, for example when people were helped to move from an armchair to their wheelchair using specialised equipment. Staff checked at each stage of the process that people were comfortable and knew what to expect next. People were presented with options, such as participating in a group or one to one activity, have a cup of tea, read their newspaper or walk with the staff. Staff checked with people if they wished to visit the toilets at regular intervals and offered to accompany them. We observed that staff were interested in what people had to say and were actively listening to them. At times there was playful banter between the staff and the people they were caring for. We spoke with two peoples spouses who said they visit almost daily, they said that the staff are always caring, and one said "They include us in the chatter, I enjoy coming and helping where I can for my wife".

The staff promoted independence and encouraged people to do as much as possible for themselves. People were dressing, washing and undressing themselves when they were able to do so. They had choice about when to get up and go to bed, what to wear, what to eat, where to go and what to do. Their choices were respected. Staff were aware of people's history, preferences and individual needs and these were recorded in their care plans. For example, people had expressed their wish to have certain meals such as breakfast in the bedroom. The staff we spoke with were aware of this and told us they always checked with people first to see whether they had changed their mind. Staff recorded in the daily notes how they had found people when they cared for them, what they had drank, eaten, but some would have benefited from

more detail being recorded. From talking to staff and the people they cared for it was obvious that they were cared for very well. As daily notes were checked by nurses any significant changes of routine were identified and monitored to ensure people's needs were met.

People were able to spend private time in quiet areas when they chose to. Some people preferred to remain in a quieter sitting area when activities took place in the main lounge. This showed that people's choices were respected by staff.

Staff addressed people by their preferred names and displayed a polite and respectful attitude. They knocked on people's bedroom doors, announced themselves and waited before entering. People chose to have their door open or closed and their privacy was respected. Staff covered people with blankets when necessary to preserve their dignity. People were assisted with their personal care needs in a way that respected their dignity.

People were involved in their day to day care. People's and the relatives we spoke with told us they had participated in a review of people's care. A relative told us, "We get invited so we can attend and bring our opinion about how our family member is cared for". People's care plans were reviewed monthly by staff who sat with people and/or their relatives to discuss people's care and support.

End of life care was provided when needed by the nursing and care staff, the registered manager told us that this was a person's home for the rest of their life when they moved in, if that was their choice. People who required end of life care were referred to specialist nurses who worked with the staff to ensure people remained comfortable. People's wishes and decisions they had made about their end of life care were recorded in their care plans when they came into the service. When people had expressed their wish regarding resuscitation this was clearly indicated in their care plan and the staff were aware of these wishes.

Good

Is the service responsive?

Our findings

People's individual assessments and care plans were reviewed with their participation or their representatives' involvement. One person said "Yes, I am aware of my care plan and I've had a review". A relative told us, "We are always informed if there are any issues, if mum is not well, they are calling in the doctor for example, we have no concerns. A second relative did say "I would like better information on her fits". Another said, "I feel very involved in her care" and "The nursing team are fantastic. They have a lovely way, and I am so pleased the staff keep me informed".

Each person's physical, medical and social needs had been assessed before they moved into the service and communicated to staff. Pre-admission assessment of needs included information about people's life history, likes, dislikes and preferences about how their care was to be provided. Care plans were developed and maintained about every aspect of people's care and nursing needs. These were person centred and based on individual needs and requirements. This ensured that the staff were knowledgeable about people's individual needs from the onset.

People's care plans included risk assessments with clear recommendations to staff about how to reduce the risk that was identified. A person who experienced falls was referred to the falls clinic, and was being provided with equipment that alerted staff when they stepped out of bed so they could provide help and reassurance. People who were at risk of pressure sores were provided with a specialised mattress and staff ensured the were checked daily and people were repositioned every two hours as stated in their care plan and risk assessment. Care plans were reviewed monthly or as soon as people's needs changed and were updated to reflect these changes to ensure continuity of their care and support. For example, a care plan had been updated to reflect a change of medicines following a G.P.'s visit and a review of their care. This showed that management and staff responded to people's changing needs whenever required.

Staff ensured that people's social isolation was reduced by making sure if they had chosen to stay in their rooms they were visited often, staff took time to chat with them and encouraged them to drink plenty of fluids. Relatives and visitors were welcome at any time and were invited to stay and have a meal with their family member. A relative said, "I come in often and usually have lunch with my wife, I miss her being at home. I also know she is better off here, the staff keep a close eye her and if she is not well they get the doctor in".

We found that staff worked in a variety of ways to ensure people received support they needed. Equality and diversity was covered in people's care plans and it details people's preferences and individuality. For example one person likes to be in her room all morning, but liked lunch at mid-day in the dining room, they then stayed down stairs the rest of the day or until they asked to return to their room. We observed that staff called people by their preferred names. Religious and cultural needs are also taken into consideration with people attending church services of their faith when they wished and clergy visiting from the local church regularly. This showed that staff supported people based on the person's choice and preference.

People were able to express their individuality. Bedrooms reflected people's personality, preference and

taste. For example, some rooms contained pictures and other items form their previous home, people were able to choose furnishings and bedding. This meant that people were surrounded by items they could relate with based on their choice.

Activities took place daily. The activities coordinator consulted people and took their preferences and suggestions in consideration before planning the activities programme. There were group activities and one to one sessions for people who preferred or who remained in their room. Activities included card games, reminiscence, boules, exercise, music, dancing and arts and craft. One to one sessions included arms and hands massages, reading aloud and sing-along. The registered manager organised activities with the activities coordinator for each month. During our visit, an entertainer visited the home to provide 'music for people. Some members of staff assisted people to take part in the activities and were singing and laughing with people. The activities co-ordinator said that recently they had been able to purchase more entertainment for the home, that he had requested further training and this was being arranged. The provider and registered manager said they saw activities an important part of the care provision in the home.

There was a weekly activity timetable and people confirmed that activities were promoted regularly with giving assistance to people who wished to join in but needed help. Peoples comments included; "The entertainment's so much better. Every afternoon something is happening" and "He (activities co-ordinator) needs a medal", "The variety of activities does cater for all residents". There was also a monthly newsletter which had just been started but was being well received. The newsletter kept people up to date with any changes and gave information about any events that were coming up.

The registered manager, her deputy and nurses contacted other services that might be able to support them with meeting people's health needs. This included Speech and Language Therapist (SALT) referral and guidance was in place demonstrating the provider promoting people's health and well-being. Information from health and social care professionals about each person was also included in their care plans. There were records of contacts such as phone calls, reviews and planning meetings. The plans were updated and reviewed as required. Contact varied from every few weeks to months. This showed that each person had a professional's input into their care on a regular basis.

The provider used an annual questionnaire to gain feedback on the quality of the service. These were going to be sent to people living in the home, staff, health and social care professionals and relatives. The registered manager told us that completed surveys would be evaluated and the results used to inform improvement plans for the development of the home. Where needed action plans would be developed to provide for suggestions made. As they have not been running the home for a year, they do not have any results currently.

People who used the service and relatives we spoke with told us they knew how and who to raise a concern or complaint with. There comments included, "No, I've never complained, not needed to", "We've never needed to complain"; "We have recently had a residents and relatives meeting so we could raise things then if we were not happy" and "I've never needed to grumble". We were shown a copy of the complaints procedure. The procedure gave people timescales for action and who in the organisation to contact. People told us that if they were unhappy they would not hesitate in speaking with the registered manager, the deputy or staff. They told us they were listened to and that they felt confident in raising any concerns with the staff. A relative told us, "If I had reason to complain I would just talk with the manager and this will be sorted straight away". No complaints had been received before this inspection.

Good

Is the service well-led?

Our findings

People told us; "The lady manager is very pleasant and kind" and "She is approachable", they also commented "Yes, it (Home) seems to be run well" Relatives told us "The manager seems OK, she is approachable" and others said "I've found the management OK", "Yes, the Home is run well" and "There have been some improvements since the new management came in" and "It (Home) is well organised" and "Things have improved since the new managers took over" and "It's wonderful here".

The registered manager here has a deputy manager and clinical lead nurse, managing the home. The staff told us, "They are all approachable; I can talk to them at any time", "I feel we are supported, and they never mind if you're not sure and want to ask" and They are all easy to talk to and the make time to listen, I find them supportive, I had a few personal issues and they were very understanding"..

A healthcare professional said, "This management is knowledgeable about people's needs, they call if they want advice and they keep us updated on people progress, there is good communication with in the home".

We spoke with the registered manager about their philosophy of care. They told us, "People must be treated as an individual who deserves to have their rights respected and receive personalised care". The provider had a clear set of vision and values under each care heading in their 'Statement of Purpose'. For example under Clients rights 'We place the rights of the clients at the forefront of our philosophy of care'; under dignity; 'Disability can quickly undermine dignity, so we try to preserve respect our clients' and under fulfilment 'We wish to help our clients to realise the personal aspirations and abilities in all aspects of their lives'. Our observations showed us that these values had been successfully cascaded to the staff who worked in the home. Staff demonstrated these values by meeting people's needs and encouraging people to make choices about their everyday lives. Staff we spoke with knew their responsibility in making sure they provided care in a way that met the values of the home. One staff member described the ethos of the home as "we are encouraging residents be themselves, making sure their needs and wishes met and treat them with respect and kindness at all times.

The registered manager oversaw the day to day management of the home. Both the registered manager and deputy manager and clinical nurse lead were knew each person living in the home by name and people knew them and were comfortable talking with them. The registered manager told us they were well supported by the provider who provided all necessary resources necessary to ensure the effective operation of the service. The provider had an office on site was on the premises most days. This showed that the registered manager and staff were well supported by the provider.

Staff understood their roles and responsibilities and told us they worked well as a team. They were able to describe these well and were clear about their responsibilities to the people and to the management team. The staffing and management structure ensured that staff knew who they were accountable to.

Communication within the home was facilitated through weekly and monthly management meetings. This

provided a forum where clinical, maintenance, catering, activities and administration lead staff shared information and reviewed events across the home. Staff told us there was good communication between staff and the management team.

We found that the registered manager had systems in place to monitor good quality assurance in the home. The registered manager undertook audits every month to make sure that monitoring had been undertaken by the responsible members of staff. We saw that monitoring tools were being completed by the responsible member of staff. Staff completed monthly audits of all aspects of the home, such as medicine, care plans, nutrition and infection control. Where audits routinely identified areas they could be improved upon and the registered manager produced action plans, which clearly detailed what needed to be done and when action had been taken. The provider had effective systems in place for monitoring the home, which the registered manager fully implemented

There were also systems in place to manage and report accidents and incidents. Accident records were kept and audited monthly by the registered manager to look for trends. This enabled the staff to take immediate action to minimise or prevent accidents. These audits were shown to us as part of their quality assurance system. The registered manager said, "We record all incidents and I investigate and also report it to higher management if need be".

Staff had access to a range of policies and procedures to enable them to carry out their roles safely. The policies and procedures had been updated by the management team and cross referenced to new regulations.

The registered manager was aware of when notifications had to be sent to CQC. These notifications would tell us about any important events that had happened in the home. Notifications had been sent in to tell us about incidents that required a notification. We used this information to monitor the service and to check how any events had been handled. This demonstrated the registered manager understood their legal obligations.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People's medicines were not managed safely. Regulation 12 (2)(a) & (b)