Heanton Limited

Heanton Nursing Home

Inspection report

Heanton
Barnstaple
Devon
EX31 4DJ

Tel: 01271813744

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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 was the first comprehensive ratings inspection for this provider. Previously this home had been registered under a different legal entity. The new registration took on February 2016. The representatives of the new legal entity were aware of improvements that needed to be made to the home following the last inspection under the previous legal entity. The inspection was unannounced and completed over two days on the 5 and 6 April 2016.

Heanton is a registered to accommodate up to 52 people and provides personal care and support as well as nursing care. Most people using this service are living with dementia. The Provider has recently developed and have begun to implement best practice care delivery based on the household model of care pioneered in the USA by LaVrene Norton, Action Pact and Steve Shields. This has resulted in the environment being divided into smaller houses to support small group living. Groups are determined based on the stage of the dementia of the person living at the home. There were four 'houses' (distinct areas within the building) which provided care for people at early stages of dementia, people living with dementia who were experiencing an altered reality. The third area was for people who were living with dementia who were in a repetitive stage and the fourth house was designated for people who were living with advanced dementia. The model of care is known as the household model. The provider has implemented this model with the support of specially recruited dementia practitioners.

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. At the time of the inspection there was a registered manager in post, however she has decided to apply to deregister with the Care Quality Commission and instead take a more active nursing role within the home. There was an interim manager already in place who had experience of managing similar services.

At the time of the inspection there were 39 people living at the service. Some of the people who had been living at this service for some time had recently been moved to different areas depending on their needs in relation to their dementia. Some relatives spoke with us about their concerns about the moves for people. Some were still getting used to different rooms, floors and staff. One relative said ''I understand why they have made these moves and I think it is a good idea, but I and (name of person living at the service) were used to being downstairs and knew the staff well.'' Another gave a more positive view saying "I can't fault the staff they are all lovely. They look after my relative and me for that matter in a very kind and caring way"

We found that although care and support was being well planned, details about whether someone's liberty was being deprived and whether the service was operating under the principles of the Mental Capacity Act 2005, were less clear within the electronic care plans. Staff were not always aware of who may be subject to a Deprivation of Liberty safeguard (DoLS) or who had an application for such a safeguard awaiting approval. The senior managers agreed the care files were not explicit enough in this area but were certain staff worked

within the main principles of ensuring people's rights and consent was always considered in their everyday practice. We saw examples of care delivery which supported this. For example staff checked with people they were happy and understood what was happening, before providing support to them. Since the inspection the manager has provided evidence to show care electronic care plans now include whether DoLS have been applied for and/or authorised.

Improvements were needed to ensure the environment met people's needs. We found some hot water outlets were running very hot which could have presented as a scalding risk to people. The provider had already identified this as an area to improve, and following our first day of inspection, called in their in-house plumber. They started work on ensuring all hot water outlets had a valve fitted to thermostatically control the hot water and therefore prevent possible risks of scalding. Tiles were missing from the corners of the platform which the washing machines stood on. This meant there were areas which could not easily be washed down to prevent cross contamination. The provider agreed to address this as a matter of urgency. Since the inspection we have seen evidence to show this was been addressed.
Whilst some of the communal areas of the home had been painted and/or decorated to provide a brighter and more stimulating environment for people, there were still areas of the home which were in need of refurbishment. We discussed this with the senior management team, who explained they had short and long term plans to address the whole environment, but that health and safety issues would be dealt with urgently and ascetic refurbishments would be an ongoing process. We found all areas clean and mostly odour free. On one day one of the lounge areas did not smell as fresh. When we fed this back the senior managers said they would organise for this area to have a deep clean that evening.

People were being supported by staff that understood their needs and worked alongside them to reassure and provide positive encouragement. For example one person was walking without obvious purpose asking for help to get the train back home. Staff talked and walked around with this person, suggesting they may need to wait for the ticket office to open, or they were not sure of the times of the train and perhaps they would like to have a cup of team whilst this was being sorted out.
Staff had received training in key areas to help them do their job safely and effectively. Ongoing support to staff had tended to be responsive but there were plans being put in place to ensure all staff had regular support and supervisions to discuss with a senior member of staff, how their work was doing and whether they had any future training needs.

There were enough staff with the right skills, available throughout the day and the evening to meet people's needs. We heard from senior managers that when they were assessing new people to come to the service, they would be looking at their individual's needs and what support they needed and this would impact on the numbers of staff they had for each shift. This meant they service would be using a dependency/needs tool to help ensure their staffing levels were right going forward. Staff said staffing levels had improved, although there had been odd occasions due to staff sickness when they had been short. The senior management team said they had recruited enough staff to be able to cover shifts and rarely needed to use agency staff unless in an emergency.

Recruitment processes ensured only people who were checked as being suitable to work with vulnerable people were employed. Staff understood safeguarding processes and how to protect people from harm. The service were working well with partner agencies to ensure people were being protected from harm.
Care was being planned in a person centred way ensuring staff understood people's history, preferred routines and things that were important to them. Activities were planned throughout the day to ensure people had access to activities they enjoyed as well as time to rest and chat with staff. Community groups were encouraged to visit and play and active part in the activities of the home. For example church services were held on a regular basis.

People's medicines were being safely managed and systems ensured their nutritional needs were being met.

The provider ensured the home was safe or that measures were being put in place to ensure safety. Audits were used effectively to review the quality of care and support being provided.

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

Most aspects of the service were safe, but some improvements needed to ensure people's safety and comfort.

The risks to people were assessed and actions were put in place to ensure they were managed appropriately, although senior management team acknowledged further work was needed on personal emergency evacuation plans.

Medicines were well managed.

Staff knew their responsibilities to safeguard vulnerable people and to report abuse.

Is the service effective?

Good

The service was effective.

People were supported by staff who were trained and supported to meet their physical, emotional and health care needs.

People were enabled to make decisions about their care and support and staff obtained their consent before support was delivered. Staff understood their responsibility under the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards to protect people.

People's dietary requirements were well met and mealtimes were unrushed and enjoyable for people.

Is the service caring?

Good

The service was caring.

People were treated with dignity, kindness and respect.

People were consulted about their care and support and their wishes respected.

Is the service responsive?

Good

The service was responsive.

Care and support was well planned and any changes to people's needs was quickly picked up and acted upon.

People or their relatives concerns and complaints were dealt with swiftly and comprehensively.

Is the service well-led?

Good

The service was well-led.

The home was well-run by a senior management team who supported their staff team and promoted an open and inclusive culture.

People and their relative's views were taken into account in reviewing the service and in making any changes.

Systems were in place to ensure the records; training, environment and equipment were all monitored on a regular basis.

Heanton Nursing 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.

This inspection took place on 5 and 6 April 2016 and was unannounced. There were two inspectors on the first day and one inspector on the second day.

Prior to the inspection we looked at information we have received in respect of this service. This included notifications. A notification is information about important events which the service is required to tell us about by law. We also looked at recent safeguarding information.

During the inspection we spoke with five people, 16 staff, seven visiting family members and two health care professionals. Following the visit we also contacted two further healthcare professionals to gain their views about the service.

We looked at records which related to seven people's individual care, including risk assessments, and people's medicine records. We checked four records relating to staff recruitment, training, and supervision. We also looked at how complaints were responded to, service safety checks and quality assurance processes.

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 comment directly on their experience.

Requires Improvement

Is the service safe?

Our findings

The manager and director were aware that a number of improvements needed to be made to the environment to improve safety. The manager planned to undertake a detailed risk assessment of all environmental risks at the service to help prioritise improvements needed. Some works had already been prioritised and were planned. For example, temperature monitoring valves were due to be installed on hot water supplies in all areas where people have access to these outlets, to comply with the health and safety executive requirement of maximum water temperatures of 44 degrees. This work had been brought forward and some valves were being fitted on the second day of the inspection. This would reduce the risk of burns/scalds for people in all areas. Other works were also planned to improve fire safety precautions throughout the home such as installation of new compartmental fire doors to reduce the risk of fire spreading. They also planned a redevelopment of personal evacuation plans (PEEP) for each person in the event of a fire. There were PEEPs in place but they wanted to improve these.

We found tiles were missing from the corners of the platform which the washing machines stood on. This meant there were areas which could not easily be washed down to prevent cross contamination. The provider agreed to address this as a matter of urgency. Following the inspection the provider sent us photos to show this work had been completed.

The legionella risk assessment and fire risk assessment had identified some areas for improvement to ensure the service was safe and complaint with the relevant laws. Most of this work had been completed but some areas still needed work to be completed. The home's action plan identified this work would be completed by end of October 2016.

We found all areas clean and mostly odour free. On one day one of the lounge areas did not smell as fresh. When we fed this back the senior managers said they would organise for this area to have a deep clean that evening.

One family raised concerns about their relative's room being accessible to others since they had moved upstairs to a different house. We saw there were star locks on some of the bedroom doors. The manager said they were looking at locks which would give people privacy but allow them to easily open from the inside. People would then be less likely to get distressed feeling they may not be able to get out of their room easily. The director explained that they wanted to ensure they got the environment right for people with dementia and this would take time. It was to be phased in based on what was needed first to keep people safe. They described how they needed to ensure there were more features and objects for people to touch, see and relate to. There were already more homely touches around each house, but the director said they wanted to extend this further to ensure the environment was right. They described this as work in progress.

Staff understood how to identify possible concerns and signs of abuse and knew who they should report this to. They confirmed they had received training and were confident any concerns raised would be followed up appropriately. One staff member said ''I know if I reported something the manager and nurse would deal

with it. We have talked about it in our staff meeting.''

Any safeguarding concerns identified had been notified to the Care Quality Commission and the local authority safeguarding team. They had been investigated and actions taken to protect people and keep them safe. Whistleblowing policies were in place and were discussed with staff, to reassure them they would be protected if they raised any concerns in good faith. There had been two alerts raised by the service and work was in progress with the appropriate agencies to follow these up. During one safeguarding meeting the commissioning team's quality assurance officer had identified that the services' policy on safeguarding needed some updating to ensure it followed local procedures. The provider agreed they would review their policy.

There was sufficient staff with the right skills available each shift to enable people's needs to be met. People who were able to give a view were positive about staff. One person told us ''The staff are fantastic.'' Another said ''There are plenty of staff. They are very good.'' Relatives we spoke with confirmed staffing levels were better than in previous months. One relative said ''The staffing levels vary, but of late it has been so much better. Some of the old staff have left, which is a shame, but some of the new staff are real gems too!'' Healthcare professionals said they felt there had been a significant improvement on the level and skills of staff available on shift. One said ''There has been significant work done to improve the skills of staff. They have done well in terms of turning the home around in a short space of time.''

The staffing and skill levels for each house had been assessed to establish recommended staffing levels. This took into account how many staff were needed to meet people individual moving and handling needs. Upstairs, staffing levels for Chichester and Bideford, was five staff, one nurse and four care staff during the day (or two nurses and four care staff). Staff confirmed that they were able to look after people well and spend time with each person when they had five staff. Five staff were on duty when we visited, staff said occasionally these levels dropped to four staff due to short term sickness, which was more difficult. All staff said staffing levels in the home had improved over the last few months and they had more time to spend with people. One staff said, "Staff is better and its feels calmer." Our observations supported this.

Downstairs for the two houses, Williamson and Tarka there were four or five care staff plus one nurse and an activities coordinator who worked Monday to Fridays. Care staff were supported by ancillary staff. There were two cooks, two kitchen assistants, two laundry staff and at least three cleaners per day shift. There was also a maintenance person. In addition there was a full time manager, administrator and support from senior clinical leads for at least one or two days per week on site and then remotely throughout the week.

All vacant posts had been filled, although a number of staff were relatively new. No agency staff were used. Where there was staff sickness or annual leave, regular staff worked extra shifts, wherever possible. This meant people were cared for all the time by staff that knew them.

Each person's care records had individual risk assessments which provided detailed information for staff about risks and how to reduce them. Staff knew people well, they could tell us about individual risks and how they reduced them as much as possible. For example, how they repositioned two people every four hours day and night because they were at increased risk of developing pressure ulcers. They also reminded people to use their mobility equipment to reduce their risks of falls.

Risk assessments and care plans were in place for pressure care. For example, one person had very fragile skin and was at risk of developing pressure damage because of their health condition and reduced mobility. Their care plan instructed staff on actions to take to prevent skin damage. The person had a pressure relieving mattress, and a pressure relieving cushion. Staff helped them to have regular changes of position

every four hours, their care plan had detailed instructions about for staff about their personal care, skin care and moving and handling needs. The nurse showed us how they checked the person's mattress regularly to ensure it was at the correct setting for their weight. Where there were ongoing concerns about wound care, nursing staff sought the advice of tissue viability specialists and followed any advice given. Where people were at risk, their skin was checked daily for any signs of redness, which would alert staff to take further actions to reduce risks.

Where there was any skin damage, such as a bruise or a break in the skin, this was recorded on a body map, so that action could be taken to promote healing and to monitor this. A healthcare professional said they had noticed a marked improvement in the recording and skills of staff in ensuring wound care, bruises and skin tears were clearly recorded and actions taken to promote healing and risk of further damage.

Two staff said there was limited information available to look at reducing the risks where people may have behaviour which may have challenged the service. When we fed this back, senior staff were able to show detailed plans of how staff should work with people to reduce their anxieties. The senior leadership team, which included a director, dementia nurse specialist and new manager, said staff needed more support in ensuring they were using the right approach with each individual. A dementia care specialist nurse had been, and continues to, spend time on each unit to work alongside staff and help them to adapt their approach in working with people with complex needs. The manager stated they would be working with commissioners to review people's complex needs and see whether there was a need for more one to one staff time to ensure people's needs were fully met.

One person had a swallowing difficulty and was at increased risk of choking. Staff said they added a thickening agent to the person's drink to make it easier for them to swallow. Where the speech and language therapist had advised the person's food was pureed, we saw these instructions were followed, and each was pureed separately, in line with best practice. These measures reduced the risks of choking for this person.

Accidents and incidents were reported. One person had a fall the previous evening and cut their hand. There was an accident report on record about this. Where a person had a number of falls, their care plan was reviewed to see if there was anything staff could do to prevent further falls, for example checking their medicines had been reviewed, ensuring the environment was safe and looking at whether the person needed mobility aids to assist them to remain independent and safe in moving around.

People received their medicines safely and on time. The service used a monitored dosage system on a monthly cycle for each person. Staff who administered medicines were trained and assessed to make sure they had the required skills and knowledge. Staff stayed with the person whilst they were taking their medicines and provided encouragement and support, where needed. Some people had medicines prescribed for mood, as needed. For example, one person was prescribed a relaxant drug for when they became restless or agitated. The prescription gave clear details about the circumstances in which this should be used, starting with the smallest dose, and reviewing to see if this was effective before giving any more. Senior staff said the use of 'as required' medicines (known as PRN) for people's behaviour was closely monitored to identify any trends. The GP and community psychiatric nurse had worked with staff at the home to review the medications of all of the people who lived there and reduce the need for PRN medication. Senior staff said the need for PRN medicines for people's behaviours had significantly reduced since the new model of care was introduced. This showed that the service were working on the way they interacted with people rather than using medicine to modify behaviours.

Medicines administered were well documented in people's Medicine Administration Records (MAR),

although we found gaps in records about whether prescribed creams had been applied.
Where a person's dosage of medicines was altered, there were systems in place to make sure the prescription was updated accordingly and the correct dosage obtained. On the day we visited, two people refused to take their medicines. A 'best interest' decision had been made that in these circumstances, the person should be offered their medicines disguised in food/drink. The nurse tried again to get the person to take their medicines and when they refused a second time, added it to their bowl of cereal (covert medication). The reason for this was documented in their record, and was in accordance with the GP's instructions.

Medicines were stored safely in the nursing office and those that required additional controls because of their potential for abuse (controlled drugs) were stored securely. Where pain patches were used for pain relief, the date and location of where the patch was applied was recorded, in line with good practice guidelines. Controlled medicines were checked by a nurse and a care staff member for security and to reduce the risks of errors.

All stock entering and leaving the home were accounted for. The temperature of the medicines room and the medicines refrigerator were monitored to ensure medicines were stored at manufactures recommended temperatures. Medicines were audited regularly with actions taken to follow up any discrepancies or gaps in documentation.

Recruitment files showed people were only employed once all checks and references was in place to ensure they were suitable to work with vulnerable people.

Good

Is the service effective?

Our findings

In January 2016 the provider implemented a best practice Household Model of care, where people living with dementia at a similar stage lived together in houses. This meant some people had moved rooms or moved upstairs, or downstairs. Senior staff confirmed people/families had been involved in those decisions and best interests meeting held for people who lacked capacity. Three months in from these changes, the feedback from staff and relatives was largely positive. Senior staff said, "People are emotionally well," and "There is some good work going on here". They said relatives and families were noticing a difference. For example, staff reported that some people living with advanced dementia in Bideford house had started to engage with staff and relatives and showed more emotion than previously. A staff member said recently they had arranged a family meal to celebrate a person's wedding anniversary and placed music from their wedding that was meaningful to them. They said the person, who previously had not showed much emotion, cried ''but they were happy tears''. Staff and relatives were pleased because they had been able to connect with the person and so they were also happier.

In Williamson house one person was walking, apparently without purpose, constantly asking for help to get the train back home. Staff talked and walked around with this person, suggesting they may need to wait for the ticket office to open, or they were not sure of the times of the train and perhaps they would like to have a cup of team whilst this was being sorted out. We saw another person had previously worked in an environment where they were in charge of people. Staff worked alongside this person taking directions and talking about the tasks which needed to be completed that day. Later we saw the person sweeping up outside and staff said this had been one of the tasks they had completed in their work life. This showed staff were working effectively with people to help them understand their world and what their memories were about.

People's consent for day to day care and treatment was sought. Where people lacked capacity, or had fluctuating capacity, mental capacity assessments were completed. Where a person was assessed as not having the capacity to make a decision, people who knew the person well and other professionals, were consulted and involved in making a decisions in the person's 'best interest'. For example, in relation to the use of bedrails, hoist, covert medication. Where a relative had power of attorney for making decisions about a person's care and treatment and their finances, this was documented in their records and there was evidence staff consulted them regularly about the person's care. This showed the service worked within the law to protect people's rights.

The Mental Capacity Act (2005) provides the legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision is made involving people who know the person well and other professionals, where relevant. These were not always evident within the electronic records but when discussed with the director we saw a file with records of best interest meetings having taken place.

Deprivation of liberty safeguards (DoLS) provide legal protection for those vulnerable people who are, or may become, deprived of their liberty. The safeguards exist to provide a proper legal process and suitable

protection in those circumstances where deprivation of liberty appears to be unavoidable and, in a person's own best interests. Staff were not clear who may be subject to such safeguards and the care plans in respect of this did not make it clear whether an application had been applied for and/or authorised. Staff could describe why such safeguards might be in place and what sorts of things may mean people were being deprived of their liberty, but this was not explicit in people's plans. The director explained that the electronic care plans were still work in progress and most information had been uploaded but there were still paper copies of some information. There was a file with DoLS applications, but as the local authority had not responded to some for up to a year, they had decided to start over with making applications to ensure the assessors had the right up to date information. Since the inspection the manager has provided evidence to show care electronic care plans now include whether DoLS have been applied for and/or authorised.

New staff had completed e –learning training but several said they felt they needed more "on the job" training. One staff said they needed some training on dementia. Three senior staff agreed new staff needed more practical training and they were implementing this. One staff said, "This is my first job in care, I want to make sure I'm doing it right." A senior member of staff said, although there were books, tools, and a range of other equipment was available to stimulate people's interest, some staff did not have the knowledge and experience yet of how to use these spontaneously to interact with people. Senior staff were providing practical examples of how to do this. Two staff had made a list of practical training which they planned to work through with newer staff. This included training to support staff to interact with people and prompt them to undertake meaningful activities. Senior staff said they planned that all care staff would complete the skills for care certificate. The Care Certificate is a nationally recognised set of standards that health and social care workers 'adhere to in their daily working life'.

Existing staff said they felt well supported to do their job and they had attended the briefing training on the new model of care. Staff said they felt the household model was working well, particularly on Bideford. Staff undertook regular update training such as safeguarding adults, health and safety, and infection control. Staff had access to a range of other care related qualifications. The service had a training matrix which showed all training completed or needed for each staff member in order to do their job effectively. Recent staff survey results showed staff were confident they were getting the right training. For example all 22 staff who have completed the survey so far said they agreed with the statement that the training they had received to date allowed them to care for people in a private, dignified and confidential manner. 21 staff said the training included face to face as well as on line courses, which were relevant to the role and the environment. A group of staff had recently been taken to London to participate in a specialist training course with other care providers on Empowerment. A member of staff who attended the course said "This was the best training that has ever been provided in the care sector"

Staff had supervision of their work individually and in groups, prioritised according to need. These included opportunities for staff to discuss their practice and identify any further training and support needs. A group of senior staff were about to take over responsibility for regular one supervision of all care staff. The training coordinator was meeting with these staff on the second day of the inspection to help them prepare for this role. This meant staff planned individual supervision to be delivered every three to four months to support ongoing improvement in practice. Annual appraisals were also planned for each staff member. The service staff survey results showed just over 70% of the 22 staff who have completed the survey knew who their supervisor was and half had been invited for formal supervision meetings to discuss their learning needs.

Each person's nutritional needs were assessed using an evidenced based tool which identified anyone at risk of malnutrition or dehydration. Where risks were identified, an individual care plan was in place about

how to meet the person's needs. For example, staff said one person ate better if they were offered small pieces of 'finger food' they could snack on throughout the day.

Where any nutritional risks had been identified, people had been referred to a dietician. Some people had been prescribed nutritional supplements to help them gain weight. Anyone at risk of malnutrition or dehydration had their food and fluid intake monitored daily, so staff were aware if someone had missed a meal and could offer them more snacks and drinks later in the day. People were weighed regularly, some weekly, some monthly. This meant any changes/risk could be spotted quickly and positive action taken. We saw that some people had gained weight since they came to live at the home.

A speech and language therapist said they had received more referrals from the home over the last few months, that staff practice had improved and therefore people were safer from the risk of choking. Recently, they had trained a number of staff from the home in managing people with swallowing/choking difficulties. They said staff were enthusiastic about the training and had a greater understanding of how to prompt people to swallow, and the importance of good posture when eating and drinking. They said when they visit they had noticed staff were more knowledgeable about people's needs.

Care records had detailed information about people's food preferences. For example, that one person liked their orange juice chilled from the fridge and that another person often got hungry in the middle of the night and liked to snack on digestive biscuits.

Where people had identified heath care needs, there was a care plan in place about how to meet those needs. For example, where a person had diabetes, their care plan included instruction for staff about their dietary needs, their medication and arrangements to monitor their blood sugar levels. This also included information about how to recognise when the person's blood sugar was too high or too low and what action to take. Daily care records showed staff acted in accordance with the person's care plan.

Where people needed equipment and adaptions to the environment to help them, these were in place. For example, one person's moving and handling plan showed they preferred a bath and needed a special seat to use the bath. Other equipment they needed to mobilise safely included grab rails, and a raised toilet seat. Staff said there was plenty of equipment available in each household area, for example, hoists, slings and other moving and handling equipment. The director we spoke with confirmed they had purchased more hoists and enough slings to ensure each person had their own.

Good

Is the service caring?

Our findings

Relatives gave very positive feedback about the caring nature of staff. One said ''I can't fault the staff, they are all lovely. They look after my relative and me for that matter, in a very kind and caring way.'' Another said ''My (relative) moved here following a long spell in hospital where they were very troubled and displaying aggression. Since being here they have settled so well. We are seeing some of the old personality and we are very pleased. Staff seems very attentive and kind.''

One person who lived at the service asked what we were doing and when we explained our role said ''The staff are brilliant. They do a good job, you couldn't ask for better.'' Another told us ''Staff are lovely here. I like it''.

We saw many examples of staff working with people in a kind and considerate way. For example, one person was sitting at the table with their head down not engaging with anyone else around them. A staff member came along, knelt on the floor and looked up at the person and touched them gently on the arm and started chatting to them. The person responded immediately with a big smile. When another person became restless the staff offered to take them for a walk and talked to them about their life in the area they grew up.

Staff provided support in a way which ensured people's dignity and respect was upheld. All personal care was completed in private. People were encouraged to maintain their dignity throughout the day. For example, staff saw someone had spilt their drink on the clothes and asked them if they would like to supported to change into fresh clothes.

Staff said since they moved into the household model of care, they had got to know people much better as individuals. This helped staff to better understand how to support people to express their views. They had worked with relatives and families to find out much more about each person's history and their lives before they came to live at the home. This was documented in a section called 'All about me' in each person's care records. For example, a staff member was helping a person to have lunch and was chatting with them about the person's love of needlecraft and painting. The person's facial expressions showed that they were responding well to this. Staff chatted to another person about their love of sailing and bird watching and they responded enthusiastically.

Relatives confirmed they had been consulted and involved in the changes made at the home to move people in to four households. The provider had sent letters to all families explaining the household model of care and the benefits for people living with dementia. Some families were concerned about the impact of moves for their relative, whilst others felt there had been positive benefits for people's emotional well-being. Relatives confirmed they were made to feel welcome and invited to social events and entertainment sessions. We saw one relative being involved in a giant game of snakes and ladders, encouraging their relative as well as others in the group.

The activities coordinator had worked hard to foster relationships with local groups such as singing groups and local clergy. When they visited this was made into a social occasion to build relationships with these

groups. For example a local singing group visited to entertain people and following this tea and cream cakes were served.

Mealtimes were sociable, relaxed and unhurried. One person spent a long time eating their scrambled egg and bacon, and staff prompted them to eat another mouthful every so often. Staff supported other people to eat and drink, as needed in a kind and respectful way. People were supported to remain as independent with eating and drinking as possible through the use of adapted plates, cutlery and glasses. Whenever someone asked for a drink or something to eat, staff responded in a cheerful and encouraging way, making sure the person's request was honoured. One staff member said ''If someone wants some toast or a biscuit at 11, we get it for them. It is all about what they want rather than saying they should wait till their lunchtime. Why should they wait if they feel hungry? It is a very caring environment here, much better than where I previously worked.''

Good

Is the service responsive?

Our findings

The senior staff team said they were hoping to phase in the move to four houses over a period of time, but realised that they needed to implement this model early in the new year to ensure they could be responsive to people's needs. For example, they wanted to ensure people who were at an advanced stage of dementia who may have more nursing needs, should have staff with the right skills to ensure these needs were being met. This included ensuring people's pressure care was carefully monitored and any risks in terms of their physical health were clearly identified for staff to follow up on. Where people were in a stage of their dementia where they may experience an altered reality, staff needed to have the right skills to connect with them and be able to help the person make sense of their memories and experiences. The division into four households meant staff could hone their skills in a particular area and those more vulnerable would be safe from others who may explore by touch or moving things around.

One relative we spoke with wasn't convinced that moving the person upstairs was the best for them as they felt they were getting less stimulated and missing out on activities downstairs, such as the musical entertainment. However, they acknowledged they thought the person was safer from other people's behaviours. We saw on the second day when music entertainment was being offered as a session downstairs, that people were brought down from the upstairs houses. When we asked about how they decided who would like to join this session, staff said they were aware of people who enjoyed music and they asked people if they wanted to join in.

People in Bideford were living with advanced dementia and were very dependent on staff to meet all their care, treatment and emotional health needs. They were unable to move independently and relied on staff support for all aspects of daily living. They were cared for in a relaxed and calm environment. When we arrived, people were sitting having breakfast, each person had a staff member helping them to eat and drink. On the second day during the afternoon, staff were talking to people about their past hobbies and discussed planting some bulbs.

A staff member said they had modelled the communal dining room/lounge on their grandmother's living room. This included soft light, ornaments, pictures and flower arrangements. There was the background sound of a budgie chirping in their cage. At the dining table, people each had their own placemat of things meaningful to them. Flowers for one person, dogs for another. In one corner, there was a curtained off quiet area with sensory lighting such as fibrotic lighting and sensory bubbles where people could spend time relaxing in a quieter environment. Staff said there were plans in place to purchase more sensory equipment to stimulate people.

Staff also said people did not have to get up each day, and some people were having a rest day in bed. Others became very tired after being up for about five hours and were supported to rest in their reclining chair or return to bed for an afternoon nap. One staff explained that people were moved at regular intervals throughout the day to stimulate them. For example, one person was seated in their armchair looking out over the view of the river. Another person was seated close to the radio.

Care records showed what support each person needed with their personal care needs. This included information about what they could manage independently and what staff needed to prompt/support them with. A monthly monitoring list was also maintained to monitor that the person received regular personal care each day. Although there were some gaps in the paper records seen, particularly at night, these details were more accurately completed on the person's electronic care records. The senior staff team had picked this up as part of the auditing and had provided training and support to night staff to assist them in improving their recording.

In addition to the electronic care records, there were some paper records in use, such as repositioning charts and records of people's personal care. This was so staff could document their care as they went along and update the electronic records, when they accessed a computer. There were some gaps in the paper records, such as gaps in records of four hourly repositioning. However, when we checked the electronic records, these were more up to date.

Audits of record keeping were carried out each week with feedback to staff to prompt them to make sure care records were detailed and comprehensive. For example, prompting staff to document in more detail how a person who lacks capacity indicate their consent and asking staff for more detail about people's moving and handling care needs.

One family confirmed they had been asked to be involved in the review of their relative's care plan and within daily notes it was clear people and their relatives had been consulted about a variety of areas which helped inform the care plan process.

The home employed two activity co-ordinators and an activity programme in each household showed the range of activities available. For example, weekly bingo, musical entertainment, a visit by 'Bob' the dog, and a choir visit.

In Chichester house there was lots of equipment to stimulate and interest people. Along the corridors, there were games and puzzles mounted on the wall at regular intervals, such as a game of noughts and crosses, an alphabet puzzle and another seaside related puzzle. One lady was enjoying looking at a picture book, a gentleman was rummaging through a box of tools, and another lady was singing to a doll, which looked like a baby.

In Williamson house, on the first day there was large scene of a fairground with props such as hook a duck, bean bags to throw at cans and other games. There was fairground music playing and the activities person was talking about the sights and sounds of fairgrounds. People looked really engaged with the visual cues and what was being talked about. Later they played a game of giant snakes and ladders. The activities coordinator kept people's interest up by being encouraging and making the game fun. There was lots of laughter and around eight people remained engaged for a lengthy period, whilst others wandered in and out and were encouraged to take part for short bursts.

A staff member told us about plans to introduce a regular afternoon tea event in Bideford household and invite people and visitors for tea and cake. There were also planning a garden party to celebrate the Queen's 90th birthday. A staff member said the service was trying to get a local League of Friends group set up and invite families of people who currently and previously lived at the home to get involved. The League of Friends is a registered charity that raises funds to improve facilities and equipment in health and social care settings.

Relatives confirmed they were able to voice any concerns. Two relatives said they had made some concerns known to the manager, about laundry going missing and about their concerns about the moves for people into different houses. Another family member asked to speak with the manager and said they were offered a timeslot later that morning to go and talk privately about their concerns.

There was stated policy about how the service dealt with complaints, which was posted in the entrance hall. This had the wrong registered manager's details, and senior staff said they would address this promptly. We reviewed the records of how complaints and concerns had been investigated and the results relayed to the complainant. Complaints were handled appropriately, although some relatives said they would like a quicker response.
Staff confirmed they were able to raise any concerns directly with any of the senior staff team. Their in house staff survey showed that all of the 22 staff who had responded said they know how to raise a complaint.

Good

Is the service well-led?

Our findings

The senior staff team leading the change from two units to four houses were experienced in using the household model of care. It was clear they had invested time in coaching and developing staff skills to implement this. They said they were proud of what had been achieved in the first three months and in how positively staff had responded to the new model of care they had introduced.

Staff were positive about the new model of care and said they understood the model ensured they worked with people in a much more person centred way. One staff member said ''I think what we have done here is really positive. I wasn't sure at first, but now I can see the difference this model makes to people. They are happy and we are getting to know them much better. I love it.''

The ethos of the service put people first. Each household had a folder which included details about staff roles and expectations of how staff should conduct themselves. Staff were encouraged to work as a team and be proud of the work they did. The ethos of the service was for staff to focus on individuals as people, rather than the daily tasks that needed to be done. The instruction for staff said, 'use your time to talk and communicate with the people you are supporting.' This included '11 minutes at 11 o' clock' where staff were asked to get together mid-morning to review how the day was going. Staff were encouraged to 'change the moment and make a difference'. Senior staff said they had noticed more positive attitudes amongst staff, and better communication within the staff team. They also reported staff had a better knowledge of each person they cared for, which we confirmed through our discussions with staff.

Senior staff said staff were much more settled and happier since the household model of care was introduced in January 2016. However, they identified staff working in the Chichester household as in need of more leadership and day to day support. This was because a senior member of care staff was on long term sick. One staff said, "Morale has been low on Chichester but it is picking up now." Another said, "The staff who work here are genuinely caring, they just need more continuity of leadership." The director and manager had reviewed the staff skills and experience of that team, they planned to relocate three senior care staff to Chichester the following week to provide additional support to this staff group. This showed they were actively listening to staff and responding to areas of weakness to ensure quality of care was maintained throughout the service.

At the time of the inspection there was a registered manager in post, however she had decided to apply to deregister with the Care Quality Commission and instead take a more active nursing role within the home. There was an interim manager already in place who had experience of managing similar services. They said their focus was on embedding progress already made to improve standards of care and further increases the clinical knowledge and skills of staff. They also said they wanted to urgently prioritise environmental improvements needed at the home, as they felt the home needed significant investment to improve the standard of accommodation provided for people. This work had already begun and they discussed their short and longer term plans to improve the environment and safety for people and staff. The in- house staff survey showed all 22 staff respondents felt maintenance issues were dealt with within an appropriate timeframe.

Staff told us felt well supported by the management staff at the home. A care worker said they appreciated that they had 'free rein' to make improvements in their household. In the recent in- house survey 20 out of 22 staff agreed the manager had an open door policy and 19 said they would be comfortable talking to the manager about an issue and believed they had the skills to manage the service.

A daily staff handover meeting was held to communicate key information about each person, whenever new staff came on duty. A daily allocation sheet was used to identify which people each staff members was responsible for providing care to that day. This ensured people's needs were well managed and staff had the right information if people's needs had changed.

A director and a dementia practitioner were visiting the service two days each week to support staff to improve practice. They also provided remote support via phone calls and computer links. This included working with staff and carrying out a range of audits and following up that any actions needed have been addressed. These included audits of nutrition and hydration, wound care, medicines management and care records. Senior staff said these audits had prompted improved practice in all the areas audited. This was supported by feedback from healthcare professionals we spoke with.

For example, following previous concerns identified about wound care, weekly audits of wound care were undertaken to ensure staff were carrying out the care outlined in the care plan. This included checks that people's pressure relieving mattresses were on the right setting and monitoring staff were following and updating wound care plans regularly. Where any improvements were needed, these were documented. For example, where there were gaps in records of regular repositioning were found, nursing staff responsible had to confirm within a couple of days, that the required improvements had been made. This meant people's care was improving continuously as staff gained skills and experience in managing wound care. Senior staff reported that staff were much more vigilant and identified and reported bruises and wounds earlier, and took action to address earlier, to prevent further skin damage. One area the identified for further improvement was the need for more accurate documentation of the use of prescribed creams and ointments. The senior team had begun work to implement improvements on the recording of this.

Accidents and incidents were monitored to identify any trends. The accident incident reports showed a significant reduction in the accidents/incident reported since the new model of care was introduced. This demonstrated safety had improved at the home. For example, the nurse said one person was falling frequently in the evening. Staff had noticed this occurred when the person was tired and after they had their evening medication. Staff decided to transfer the person to their room and get them ready for bed before they had their evening medication. This change of practice had significantly reduced the person's risk of falls in the evening.

Monitoring of accidents and incidents had also highlighted concerns about care practice amongst individual staff, which were investigated and dealt with under the provider's capability and disciplinary procedures. This showed the increased vigilance was identifying and addressing any care issues to continuously improve people's care.

The service had various ways of gaining feedback from people living at the home, their relatives and staff. The care plan daily records encouraged staff to assign a value to an interaction showing whether the person was engaged and happy or otherwise. Using this helped the service to map responses to various situations for individuals. We saw people being asked if they were okay, if they needed anything throughout the day. Relatives were invited to give written or verbal feedback and we saw several relatives meeting with the manager on the days we inspected. Staff said they had staff meetings, supervisions and daily handovers in which to voice their views and discuss any concerns or suggestions.