Care UK Community Partnerships Ltd

Heather View

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection took place on 26 and 28 July 2016 and was unannounced. Heather View is a large purpose built house that provides accommodation and nursing care up to 74 older people, some of whom live with dementia. There were 68 people living in Heather View at the time of our inspection, two thirds of whom lived with dementia.

People were accommodated in three different units. Ashdown unit provided residential dementia care on the ground floor; Broadstone unit provided nursing care and Chelswood unit provided residential care, on the first floor and second floor. These units were connected via stairs and three passenger lifts.

There was a manager in post who was registered with the Care Quality Commission (CQC). A registered manager is a person who has registered with the CQC 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.

Staff knew how to recognise signs of abuse and how to raise an alert if they had any concerns. Risk assessments were centred on the needs of the individual. Each risk assessment included clear measures to reduce identified risks and guidance for staff to follow or make sure people were protected from harm. Accidents and incidents were recorded and monitored to identify how the risks of recurrence could be reduced.

There was a sufficient number of staff deployed to meet people's needs. Thorough recruitment procedures in place which included the checking of references.

Medicines were stored, administered, recorded and disposed of safely and correctly. Staff were trained in the safe administration of medicines and kept relevant records that were accurate.

At our last inspection in July 2015, we had identified shortfalls relevant to laundry processes. At this inspection we found that all necessary improvements had been implemented.

Staff knew each person well and understood how to meet their support and communication needs. Staff communicated effectively with people and treated them with utmost kindness and respect. People were able to spend private time in quiet areas when they chose to.

Staff received essential training, additional training relevant to people's individual needs, and regular one to one supervision sessions.

The CQC is required by law to monitor the operation of Deprivation of Liberty Safeguards (DoLS) which applies to care homes. Appropriate applications to restrict people's freedom had been submitted and the least restrictive options had been considered. Staff sought and obtained people's consent before they

helped them. People's mental capacity was assessed when necessary about particular decisions. When applicable, meetings were held to make decisions in people's best interest, as per the requirements of the Mental Capacity Act 2005.

The staff provided meals that were in sufficient quantity and met people's needs and choices. People told us they enjoyed the food and their meal times. Staff knew about and provided for people's dietary preferences and restrictions.

At our last inspection in July 2015 we had identified shortfalls in regard to people's care planning. At this inspection, we found that improvements had been implemented. People's individual assessments and care plans were person-centred, reviewed monthly or when their needs changed. Clear information about the service, the facilities, and how to complain was provided to people and visitors. Relatives told us that staff and management were "excellent at communication."

Staff developed a positive rapport with people and placed their wellbeing at the heart of their practice. Great attention was paid by staff to details about how to enhance their comfort and make people's experience in the home pleasurable. A relative described staff general attitude towards people as "exceptionally caring".

People were promptly referred to health care professionals when needed. Personal records included people's individual plans of care, life history, likes and dislikes and preferred activities. The staff promoted people's independence and encouraged people to do as much as possible for themselves.

At our last inspection in July 2015, we identified a lack of meaningful activities. At this inspection, we found that improvements had been implemented and that a wide range of meaningful activities and outings were provided. People were involved in the planning of activities that responded to their individual needs.

Staff told us they felt valued and supported by the registered manager, the management team and the provider. The registered manager was open and transparent in their approach. They placed emphasis on continuous improvement of the service and promoted links with the community.

There was a robust system of monitoring checks and audits to identify any improvements that needed to be made. The management team acted on the results of these checks to improve the quality of the service and care.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe. There was a sufficient number of staff deployed to ensure that people's needs were consistently met to keep them safe. Safe recruitment procedures were followed in practice.

Medicines were administered safely. There was an appropriate system in place for the monitoring and management of accidents and incidents.

Staff knew how to refer to the local authority if they had any concerns or any suspicion of abuse taking place.

Risk assessments were centred on individual needs and there were effective measures in place to reduce risks to people.

Is the service effective?

Good

The service was effective. Staff were appropriately trained and had a good knowledge of how to meet people's individual needs.

People were supported to make decisions and were asked to consent to their care and treatment. Where they were unable to make their own decisions the principles of the Mental capacity Act 2005 were followed to protect their rights. The registered manager had submitted appropriate applications in regard to the Deprivation of Liberty Safeguards and had considered the least restrictive options.

People were supported to be able to eat and drink sufficient amounts to meet their needs and were provided with a choice of suitable food and drink.

People were referred to healthcare professionals promptly when needed.

Is the service caring?

Outstanding

The service was outstandingly caring.

Staff communicated effectively with people and treated them with utmost kindness, compassion and respect. They took time to develop a positive rapport with people whom they valued and were particularly attentive, respectful and patient. They were pro-active and prioritised people's wellbeing in their practice.

Staff promoted people's independence and encouraged them to do as much for themselves as they were able to. They respected their privacy and dignity.

Appropriate information about the service was provided to people and visitors. Relatives described the way staff and management communicated with people and families as, "especially good".

Is the service responsive?

Good

The service was responsive to people's individual needs.

People or their legal representatives were invited to be involved with the review of people's care plans. People's care was personalised to reflect their wishes and what was important to them.

The delivery of care was in line with people's care plans and risk assessments. There was a suitable amount of daily activities that were inclusive, flexible and suitable for people who lived with dementia.

People and their relatives' views were listened to and acted on.

Is the service well-led?

Good

The service was well-led.

The registered manager promoted an open and positive culture which focussed on people. They promoted links with the community.

The provider and the management team sought feedback from people, their representatives and staff about the overall quality of the service. They welcomed suggestions for improvement and acted on these.

Emphasis was placed by the management team on continuous improvement of the service. A robust system of monitoring checks and audits identified any improvements that needed to be made and action was taken as a result.

Heather View

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 carried out 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.

At our last inspection on 31 July 2015 concerns had been identified about laundry, care planning and activities. The provider had sent an action plan to us detailing how they planned to remedy this. At this inspection, we also checked that improvements had been made.

This inspection was carried out on 26 and 28 July 2016 and was unannounced. Two inspectors inspected the service on the first day and one inspector on the second day. The inspection team was supported by 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.

The manager had not received and completed a Provider Information Return (PIR) at the time of our visit. The PIR is a form that asks the provider to give some key information about the service, what the service does well and what improvements they plan to make. We took this into account when we made the judgements in this report. Before our inspection we looked at records that were sent to us by the manager and the local authority to inform us of significant changes and events. We also reviewed our previous inspection report.

We looked at 14 sets of records which included those related to people's care and medicines. We looked at people's assessments of needs and care plans and observed to check that their care and treatment was delivered consistently with these records. We reviewed documentation that related to staff management and six staff recruitment files. We looked at records concerning the monitoring, safety and quality of the service, menus and the activities programme. We sampled the services' policies and procedures.

We spoke with 14 people who lived in the service and nine of their relatives to gather their feedback. Although most people were able to converse with us, others were unable to, or did not wish to communicate. Therefore we also used the Short Observational Framework for Inspection (SOFI). SOFI is a

way of observing care to help us understand the experience of people who could not talk with us.

The registered manager was on annual leave during our inspection. We spoke with the operations support manager, the deputy manager, the clinical lead, two nurses, six care workers, the activities coordinator, the head chef, and the person responsible for the maintenance of the premises. We also spoke with a local authority safeguarding assessor, a local authority case manager and a specialist Clinical Commissioning Group (CCG) nurse assessor. We obtained feedback about their experience of the service.

Good

Is the service safe?

Our findings

People told us they felt safe living in the service. They said, "Having staff around makes me feel safe", "There is always someone around if I need help", "This building makes me feel safe and not claustrophobic, I can get around easily in my chair" and "There is always enough staff." Relatives told us, "I went into the garden today and I was happy to leave my wife in their care because I know she is safe with the staff" and "[X] can wander around here, it is very safe."

There was a sufficient number of staff to meet people's needs in a safe way. Staffing rotas indicated sufficient numbers of care and nursing staff were deployed during the day, at night time and at weekends. The registered manager reviewed staffing levels regularly using a dependency tool that took account of people's specific needs. Additional staff had been deployed when necessary, such as when cover was needed while staff attended training, when people needed particular one to one support and at the end of a person's life. People's requests for help were responded to without delay.

Staff who worked in the service understood the procedures for reporting any concerns. All of the staff we spoke with were clear about their responsibility to report suspected abuse. All care and nursing staff had received training in the safeguarding of vulnerable adults. There was a detailed safeguarding policy in place in the service that reflected local authority guidance. This included information about how to report concerns and staff knew they should report to the local authority or the police if necessary. Staff were aware of the whistleblowing procedure in the service and staff we spoke with expressed confidence that any concerns would be addressed.

The premises were safe for people because the home, the fittings and equipment were regularly checked and serviced. The person responsible for the maintenance of the premises showed us how safety checks were planned, carried out throughout the home and monitored effectively. They described the system as 'fool proof'. Several checks relevant to the environment were carried out by a contractor commissioned by the provider's facilities department. These were appropriately scheduled, completed and updated. A back-up system for a nurse call unit had just been installed. Equipment that was used by staff to help people move around and adapted baths were checked and serviced regularly.There was a wide range of environmental risk assessments and any deterioration of fittings or furniture was promptly identified for action. Repairs to be prioritised were logged in a maintenance book, and their progress was monitored weekly and quarterly by the registered manager. The registered manager or delegated staff completed a daily walk-around to check the general condition of the home, its cleanliness, communal areas and any health and safety issues were identified in the maintenance book.

Systems were in place to ensure the service was secure and visitors were identified by reception staff before they accessed the units. A security system ensured that people remained safe inside the service and people were assisted or accompanied by staff when they wished to access other floors.

Staff had received appropriate training in fire safety and were familiar with the steps to be taken in case of a fire. There was appropriate signage about fire exits and fire protection equipment throughout the service.

Regular checks on fire equipment were carried out and monthly fire drills were completed in accordance with the home's policy. There was a detailed fire risk assessment in place. There were detailed plans in place concerning how the service would manage an emergency. This included information about alternative in case of an evacuation. People had individual personal emergency evacuation plans in place which detailed the level of assistance they would require if it was necessary to evacuate the service. These plans were updated regularly and were included in 'fire boxes' by the exits for quick access if needed.

Accidents and incidents were being monitored to identify any areas of concern and any steps that could be taken to prevent accidents from recurring. Staff entered appropriate logs in the computerised system and made the clinical lead aware of the incidents on the day for action. Accidents and incidents were audited monthly by the clinical lead to identify any trends or patterns. One audit showed that a person experienced falls in early mornings. As a result of the audit, a medicine review had been carried out and the timing of their breakfast and medicines had been altered; an additional sensor mat was placed in their room, and a referral to a fall prevention clinic had been made. All beds could be lowered to the floor and several people were provided with 'crash mats' that enabled them to gently slide onto the floor rather than fall.

Risk assessments were centred on the needs of the individual and were reviewed monthly, or sooner when people needs changed. Staff were aware of the risks that related to each person. There were specific risk assessments in place for people who may experience choking, skin damage and who were at risk of falls. One risk assessment was in place for a person who chose to self-administer their medicines and another for a person who preferred bed rails to a 'crash mat'. Each risk assessment included clear measures for staff about how to keep people as safe as possible, taking into account people's individual circumstances and preferences. Staff applied these measures in practice, for example following specific instruction for repositioning a person in bed. Staff helped people move around safely and checked that people had the equipment and aids they needed within easy reach.

All aspects of people's medicines were managed safely. People had their medicines at the time they were to be taken. Systems for ordering, stock control and returns of medicines were orderly and easy to follow. The nurses who administered people's medicines completed the medicines administration records (MARs) appropriately and a team leader acted as second signatory for controlled medicines. Medicines to be taken 'as required' such as pain relievers were administered appropriately in line with individual protocols that detailed signs of pain to observe and respond to when people may not be able to communicate their discomfort. Topical creams were appropriately applied according to individual body maps.

Staff were trained and competent in administering medicines safely to people. Competencies had been checked in the administration of medicines for all administering staff, including managers in 2016. These competencies were based on self-assessments and observed practice, signed off by the clinical lead. The clinical lead was trained and competent in the setting up of a syringe driver (portable pump which allows medicines to be administered by slow release over a period of 24 hours).

As medicines were stored appropriately, they were safe to use. Medicines requiring refrigeration were stored in a dedicated fridge. The temperature of the fridge and the room in which it was located was monitored daily to ensure the safety of medicines they contained. Medicines trolleys and clinical rooms were locked securely when not in use. The clinical lead audited medicines monthly and wrote action plans when necessary. An audit had led to expiry dates to be noted when eye drops had been opened, and an update of protocols in medicines to be taken 'as required'. The medicines policy was clear and followed by staff. A review of the policy was scheduled in August 2016.

The home was clean, tidy and well presented. All units were pleasant smelling and free of dust or clutter. All

bathrooms and toilet facilities were gleaming. All windows were clean and allowed light to shine throughout the three units. People were very complimentary about the domestic staff. A person told us, "The place is always that clean, they are always tidying up and emptying bins and cleaning, they often talk with us at the same time, they are lovely." Steps were taken to protect people from the risk of acquiring an infection. Cleaning schedules were checked daily and included wheelchairs, mattresses, hoists, slings and bath hoists. Laundry was segregated and soiled items were cleaned at the required high temperature. There was an infection control policy in place that provided clear guidance for staff concerning the steps they should take to protect people from the risk of infection. The staff were knowledgeable of the policy, wore appropriate personal protection equipment and followed good hand hygiene practice.

Thorough recruitment procedures were followed to check that staff were of suitable character to carry out their roles. Criminal checks had been made through the Disclosure and Barring Service (DBS) and staff had not started working at the service until it had been established that they were suitable. Staff members had provided proof of their identity and right to reside and to work in the United Kingdom prior to starting to work at the service. References had been taken up before staff were appointed and references were obtained from the most recent employer where possible. There was a system in place for checking and monitoring that nurses employed at the home had appropriate professional registration. All new staff had been provided with a job description and a values statement that included their responsibility about safeguarding people from harm.

People and their relatives could be assured that staff were of good character and fit to carry out their duties. Disciplinary procedures were followed and action was taken appropriately by the registered manager when any staff behaved outside their code of conduct. Disciplinary procedure had been followed in relation to concerns about the practice of a particular staff member.

Good

Is the service effective?

Our findings

People said the staff gave them the care they needed. They told us, " The staff are fantastic, they bend backwards to make sure I have all I need; I used to be a nurse and watch with a critical eye what they do and I can't fault them" and, "I feel very lucky to have such good staff around, they are really spot on and they understand me." A relative told us, "All needs are met; they [staff] are very efficient."

Staff received essential training to enable them to carry out their roles effectively. New staff received a thorough induction that incorporated the Care Certificate during the first twelve weeks. This certificate was launched in April 2015 and is designed for new and existing staff, setting out the learning outcomes, competencies and standard of care that care homes are expected to uphold. Essential training was provided that included dementia care, mental capacity, safeguarding, infection control and manual handling. On average, 90% of staff were up to date with their training. There was an effective system to record and monitor staff training and highlight when refresher courses were due. Staff were reminded to attend scheduled refresher courses.

Additional training that was relevant to people who lived in the home was offered and delivered to staff, such as enhanced dementia training 'Fulfilling Lives', behaviours that challenge, and care planning. The staff we spoke with were positive about the range of training courses that were available to them. A member of staff said, "I actually enjoy the training, I like the mixture of e-learning and face to face and we can always ask for a refresher course ahead of schedule if we need it." Informative leaflets about specific conditions such as Cancer and Motor Neurone Disease (MND) were provided appropriately to staff to inform their practice.

Staff were encouraged to gain qualifications and progress their careers through the service. They received a minimum of three monthly one to one supervision sessions and were scheduled for annual appraisal of their performance. 42% of staff had a Level 3 qualification in health and social care and 9% of staff were studying to gain this qualification.

Staff were well supported in the carrying of their roles and told us they felt valued by the management team and the provider. Every month, staff, people or their relatives were invited to nominate any members of staff for a 'Going the Extra Mile' (GEM) award. Winners were rewarded with a gift voucher and a certificate, and entered a regional competition. An award ceremony took place on a 'staff awards night'. A member of staff told us, "This is fun; it boosts morale and motivates us to do even better." A member of the housekeeping staff had been nominated and awarded for their contribution towards people's wellbeing. A relative told us, This person has built a very good rapport with the residents and always spends time to chat with them while doing her work. It is good to see this has been recognised."

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as

possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

Appropriate applications to restrict people's freedom had been submitted to the DoLS office for people who needed continuous supervision in their best interest and were unable to come and go as they pleased unaccompanied. The registered manager had considered the least restrictive options for each individual. The CQC had been appropriately notified when DoLS applications had been authorised. People living with dementia who were subject to DoLS were provided with easy-to-read pictorial information that explained the concept of the DoLS.

Staff were trained in the principles of the MCA and the DoLS and were able to tell us of the main principles of the MCA. Assessments of people's mental capacity were carried out when necessary. When people did not have the mental capacity to make certain decisions, meetings were held with appropriate parties to decide the best way forward in their best interest. An assessment of a person's mental capacity had been carried out for a person who chose to have bed rails in place, for a person who declined to receive medicines, and for people whose consent was needed to remain and live in the home.

Staff sought consent from people before they helped them move around, before they helped them with personal care and with eating their meals. A person told us, "If I don't consent, then it is not done." People signed consent forms about their care and about the taking of their photographs when they had been assessed as having the relevant mental capacity. People's legal representatives had been invited to attend reviews of people's care plans with their consent, and requested to sign on people's behalf when appropriate.

People were involved in their day to day care and in the reviews of their care plans when they were able to and when they wished to be. There was a key workers scheme and people we spoke with knew who their key worker was. A key worker is a named member of staff with special responsibilities for making sure that a person has what they need.

There was an effective system of communication between staff to ensure continuity of care. Staff handed over information about people's care to the staff on the next shift twice a day. Information about new admissions, accidents and incidents, referrals to healthcare professionals, people's outings and appointments, medicines reviews, people's changes in mood, behaviour and appetite was shared by staff appropriately. The handovers we looked at provided clear information about a person having declined food and who was appearing unwell, and of the actions that had been taken as a result. Follow up action was taken from one staff shift to another.

There was an effective method of communication between relatives and staff. Relatives had suggested a wiping-board to be placed in people's bedrooms with people's consent. This had been implemented and was used to relay messages to staff during visits, about people's mood or preferences about the routine of that particular day. A relative told us they preferred to use a calendar and wrote schedules of their next visits so that staff could 'catch them' and talk with them if needed. Staff also wrote in the calendar any scheduled medicines reviews so as to inform the relative.

People told us they enjoyed the food they had and told us they were very satisfied with the standards of meals. They told us, "It is always lovely and tasty." One person described her meal as, "beautiful, beautiful."

A relative told us, "The food is good, I often eat here." Several people had their breakfast late in the morning as they preferred, and cooked breakfasts were available when requested. We observed lunch being served in the dining area and in people's bedrooms. Attention was paid to make the dining experience enjoyable as each table was nicely laid out with table cloth, flowers, a menu and a jug of water. The lunch was freshly cooked, hot, well balanced and in sufficient amounts. People were offered a choice of two main courses and of alternatives. A lighter cooked meal was served at supper time and people were served a selection of refreshments and home-made cakes or biscuits three times a day. A person had requested a cup of tea in between and this was provided without delay.

People were supported by staff with eating and drinking when they needed encouragement and care workers respected people's pace. Aids were used when people needed them, such as plate guards and new plates that were bowl-shape to prevent spillage. In the dining areas, care workers gave people choice by showing them the two dishes and two desserts of the day and people were able to change their mind on the day and get an alternative if they wished.

The head chef was supported by three kitchen assistants. They consulted people and their relatives in order to gain an understanding of people's preferences and needs, and wrote menus taking account specific requirements. One person liked a particular brand of cheese and the chef had gone to a specific shop to acquire it. Current records of people's dietary needs, preferences and allergies were displayed in the kitchen.

People were weighed monthly or weekly when there were concerns about their health or appetite. The clinical lead audited weighing records every month and when necessary people's food and fluid intake was appropriately recorded and monitored. Such charts were in place for anyone who could not pour their own drink, and included desired outcomes to achieve taking into consideration the hot weather. When fluctuations of weight were noted, people were referred to the GP or a speech and language therapist (SALT) when necessary, and their recommendations were followed in practice, such as providing them with thickened fluids or helping them sit in a particular position when eating.

People's wellbeing was promoted by regular visits from healthcare professionals. People were able to retain their own GP or were registered with a local GP surgery. A chiropodist visited regularly to provide treatment for people who wished it. An optician service visited every six months or sooner when needed. People were offered routine vaccination against influenza when they had consented to this. When people had become unwell, they had been promptly referred to healthcare professionals. A Continuing Health Care (CHC) visited the home regularly jointly with a local authority social worker, to oversee people's wellbeing and discuss pre-empt problems and avoid admissions of people to hospitals as much as possible. They provided advice and support to staff with clinical issues. This ensured that staff responded effectively when people's health needs changed.

The accommodation was spacious, comfortable and welcoming. There was ample provision of quiet spaces where people and their visitors could sit and relax, as each unit had one to four lounges. Lounges had a variety of chairs and each had an individual character. They included large televisions with subtitles and a variety of board games. One contained an electronic keyboard for people to use. All areas were wheelchairs accessible and furnished with comfortable armchairs. En-suite toilet facilities and 'wet rooms' had good access space for staff to give assistance as needed. Peoples' bedrooms were spacious and included some of peoples' furniture to make them feel at home. A system of air conditioning was operated on hot days to ensure people remained comfortable. People had access to a well-stocked enclosed garden when they wished, which had raised flower beds and comfortable new garden furniture. The premises were well decorated and maintained. The ground floor included an indoor 'Village Green' which was reminiscent of a

typical rural Sussex village, with village signs, a post box, an old style tea room, a contemporary 'Café', a hairdressing salon, a cinema and a small shop. The Café offered ample seating and a piano for groups to gather in during activities or for people, relatives and members of the community to attend a 'dementia group'. People's art work and photographs of their participating in activities such as a pottery class were on display. There was access to the internet throughout the premises and newspapers were available for people to read.

There was some pictorial signage in the home to help people gain information. However there were no pictorial signs in corridors to help people find the lounges and dining room. The deputy manager told us that a plan was in progress to develop more signage, a pictorial menu and a visual panel to describe activities on offer for people who lived with dementia. There was a pictorial guide in each bedroom to inform people about what to do in case of a fire. Bedrooms doors had adjacent memory boxes to help people find their bedroom and express their individuality. The activity coordinator was in process of filling them with people during one to one activities. They told us, "This project takes time because this must be meaningful for people."

Outstanding ☆

Is the service caring?

Our findings

People told us they were extremely satisfied with how the staff cared for them. They said, "I can't think of anything they could do better" and described the staff as, "wonderful, ever so kind." One person told us, "I feel privileged to live here because the staff are so caring; we are a family away from family here, capital 'F'." A person told us, "They do anything to keep me happy, like a princess really." Relatives told us, "My mother has sensory impairment and they have placed her next to the office where people regularly pass and can check on her, they are all wonderful" and, "She likes to dance and a particular care worker will often take my mum's hands and dance with her", and, "I visit several times a week; I see a lot when I am here and I have never heard any of the staff talk in any other way than in a kind and caring manner." A relative described a member of staff who had been nominated for the home's 'Go the Extra Mile' award as "fantastic", and the staff general attitude towards people as, "exceptionally caring."

Visitors were welcome at any time without restrictions and were warmly greeted by reception staff. We spent time in the communal areas and observed how people and staff interacted. There was a homely feel to the service and frequent friendly and appropriately humorous interactions between staff and people whom staff addressed respectfully by their preferred names. Some members of staff sat to converse with people and showed genuine interest in them. Staff were vigilant, checking on people's wellbeing while respecting their space and privacy. We heard staff interacting with people in their bedrooms and found that all staff were attentive, kind, respectful and patient. They had built a positive rapport with people that promoted friendship and respect.

The staff approach was pro-active as they pre-empted ways to ensure people's wellbeing. For example we heard a member of staff asking a person, "Would you like me to get you a coffee; would you like me to move this where you can reach better; would you be more comfortable if I moved your chair, is your hair still wet may I check; do you need your glasses?" and, "What can I do for you that would cheer you up today; shall we sing that lovely song that you like?" A person told us how a care worker always ensured they had their favourite music playing on the radio while they ate. A member of staff who was escorting a person to a bathroom gently repositioned another person's head on a cushion as they slept. Staff valued people and a member of staff told us, "We know them but they always teach us, we learn so much from the residents." A person who lived in the home had given lessons to care workers about flower arrangements.

People were assisted discreetly with their personal care and bathing needs in a way that respected their dignity. Staff placed signs on people's doors that said 'I am being assisted please do not disturb' when they helped people with their personal care. A person told us, "All the staff are always respectful and they understand about giving us some privacy for things like washing and showering." Bathrooms had privacy curtains so to prevent any intrusion that may disturb their sense of dignity while bathing. Staff told us people could have 'as many baths or showers as they liked' and people we spoke with confirmed this. People were encouraged to personalise their bedrooms as they wished and bring their own articles of furniture to make them feel at home from the beginning of their stay.

Staff knew how to communicate with each person. Staff lowered their position so people who were seated

could see them at eye level. They used people's correct and preferred names, spoke clearly and smiled to engage people who smiled in return. They showed interest in people's response and interacted positively with them. Staff noted people's body language when they were not able to communicate verbally. A person appeared anxious and staff went to fetch their favourite doll. They told us, "I knew this is what she wanted." When people had hearing impairment, their communication care plans indicated how best to talk with them and be understood. A person's care plan in communication included instructions to staff to enunciate clearly, to take account of the person's memory loss and possible agitation, and guidance about how to calm them down while talking with them. We observed staff following these instructions in practice.

Staff thought of innovative ways to meet people's psychological needs. For example, as two people loved horses, two pet ponies had been commissioned to visit the home and had been stationed inside the home on the ground floor to be petted. A person who enjoyed boat-watching told us, "Last week they took me to a yachting place; I get a little breathless so they watched over me."

Staff were careful to speak about people respectfully and maintained people's confidentiality by not speaking about people in front of others. People were given the choice of having their doors open or closed; people's records were kept securely to maintain confidentiality. When appropriate, independent mental health advocates (IMCAs) had been enlisted to help represent people's views at best interest meetings when families were not available.

Staff encouraged people to do as much as possible for themselves. Staff checked that people were appropriately dressed and all people were well presented with comfortable clothing and footwear. People washed, dressed and undressed themselves when they were able to do so. People followed their preferred routine, for example some people chose to have a late breakfast, remain in their bedrooms, or stay in bed. At mealtimes and during activities, people chose where they liked to sit. Staff presented options to people so they could make informed decisions, such as what they liked to eat, to wear or to do, to promote their independence. A person visited local shops after their mental capacity and any relevant risks had been assessed, and a member of staff followed them respectfully at a distance so as to offer help if needed. A person liked to do housework and was helping staff with light vacuuming. Several people kept alcohol in their bedroom fridge after any associated risks had been assessed by staff, such as possible interference with their medicines. People were able to visit other people on other floors at any time and were encouraged to form and develop friendship with others. A person told us how they enjoyed having a shower three times a week during hot weather. They said, "I do it myself, the staff just keep an eye in case I need them."

Clear information about the service and its facilities was provided to people and their relatives. A customer relations manager was on-site to talk with any visitors who wished to have information on the home and its facilities. They were provided with a folder titled 'Introducing the best of care' that contained a brochure bespoke to Heather View, a brochure about how the provider aimed to meet the needs of people living with dementia, a sample of recent activities and outings programme and breakfast, lunch and dinner menus. The reception area displayed informative leaflets on Alzheimer's and memory loss, of an independent financial advisor about 'funding your future care' and leaflets from local dementia social groups. A 'Resident's guide' described every aspect of the service, the provider's philosophy of care and clearly outlined the procedures to follow about how to lodge a complaint. There was a website about the service and sister services that was informative, well maintained and user-friendly.

Clear information of people's key workers, of who was the 'resident of the day' and of the team on duty was displayed on each floor. A new member of staff told us how they had been formally introduced to a person's family so they could develop a good rapport centred on the person's care needs and wellbeing. The resident

of the day scheme meant that staff focused and celebrated that person during a particular day of the month, and checked all aspects of their care and relevant documentation.

People could be confident that best practice would be maintained for their end of life care. People or their legal representatives were consulted about how they wished the service to manage their care and treatment when they approached the end of their lives. When appropriate, people were invited to take part in 'advance care plans' (ACP) and were supported by staff during the process. These plans give people the opportunity to let their family, friends and professionals know what was important for them for a time in the future where they may be unable to do so. This included how they might want any religious or spiritual beliefs they held to be reflected in their care; their choice about where they would prefer to be cared for; which treatment they felt may be appropriate or choose to decline; and who they had wished to be their legal representative. People had pain management plans and plans were written in advance in regard to their possible use of pain relief medicines, to avoid any delay should people's needs suddenly increase when they approached the end of their life. The home was well supported by a local hospice palliative care specialists who offered guidance when needed.

Good

Is the service responsive?

Our findings

People gave us very positive feedback about how staff responded to their needs. They told us, "They are very open here, I can talk to anyone who comes in if I have a problem", "I can bathe when I want and get my hair done every week", "I tell them [staff] what I want and it gets done" and, "Sometimes I join in the activities but the care workers know I prefer to watch." Relatives told us, "When mum first came here I used to come in and she would be in her room watching TV, I told them No this isn't my mum, she loves to socialise and needs to be encouraged to do so, they listened and that has never happened again; now she is always occupied" and, "I attend the relatives meetings every two months; it is a great opportunity to praise what they do well or could do better, and they listen."

People's needs had been assessed before they moved into the home to check whether the service could accommodate these needs. A sister home's manager carried out assessments of needs when people lived out of area. These assessments gave a clear account of people's needs in relation to their medicines, communication, nutrition, continence, skin integrity and mobility. They were person centred and noted people's family history, their interests and special requirements about end of life care when people wished to talk about this. People were invited to stay for short periods before they made an informed decision about coming to live into the home.

There were risk assessments that were carried out before people came into the service, such as risks of falls or of skin damage. This information was included in an initial care plan that was completed within 48 hours when people moved into the service. Individualised care plans about each aspect of people's care were developed further as staff became more acquainted with people, their particular needs and their choices. Equipment to reduce possible risks was put in place before or soon after a person came to live in the home, for example special mattresses, bed rails or sensor mats to alert staff when people got out of bed and may need help.

People's care plans reflected their current needs as these were reviewed and updated appropriately. Nurses or team leaders, overseen by the clinical lead, reviewed people's care plans on a monthly basis, or as soon as needed, for example following an illness, any incidents, a medicines review or a period of hospitalisation. Staff sat with people to involve them during the reviews of their care, when they were able and willing to contribute. A summary of people's care plans was sent to people's relatives or legal representatives before the reviews and they were invited to input their comments or attend the review meetings. A relative told us, "I always see staff around when I come and visit they always chat to me and keep me informed of any changes in mum" and another relative told us they were regularly contacted when their loved one was the 'resident of the day'. On that particular day, staff focused on a named resident to ensure all their risk assessments and care plans had been appropriately updated; the head chef, the activities co-ordinator and the housekeeping manager visited them to gather their feedback about their overall satisfaction of the service, and their relatives or friends were contacted to obtain their input.

People's likes, dislikes and preferences were taken into account. Staff enquired with people and their relatives about any particular fear they may have, and recorded their preferences about all aspects of their

routine, activities and food. Lifestyle questionnaires were completed about people's early years, teenage years, adulthood, and places they had travelled to. This included a range of options of preferred activities. This helped staff appraise each person's individuality, taste and preferences. When people had requested to be cared for only female staff, to go to bed late and to have a certain food, this was implemented. We asked members of staff to tell us about people's preferences and they were aware of these.

Staff placed emphasis on the promotion of good health. Several people were of an advanced age and centennial birthdays were particularly celebrated. A relative told us how at first their loved one was 'terrified about so many things' and that now, after only a few weeks, they were 'a different person." Another relative told us how the staff had provided a wrist alarm to alert them of this person having difficulties, when they had disliked wearing an alarm around their neck. A person who had come to receive palliative care had made a remarkable recovery and was now 'up and about'. Their relative told us, "It is all due to good care and attentive staff."

When we last inspected the home in July 2015, we found that there was a lack of consistent meaningful activities for people. The provider has taken action to improve this and this inspection we found that a wide range of daily activities that were suitable for older people and people who lived with dementia was available. The activities coordinator had researched original activities and helped develop an understanding of people's interests by talking with them, reading their lifestyle questionnaires and their social care plans. A person who used to be a farmer and another who used to enjoy rugby were provided with magazines and books on these subjects. One person who liked knitting had been paired with another to socialise and work on a joint project. Monthly activities programmes included quizzes, chair exercises, gardening in a dedicated gardening room with raised flower beds, music therapy, reminiscence, arts and crafts that included the making of personal scrapbooks.

Additional entertainment was sourced externally and there were frequent visits from 'Pat dogs', singers, story tellers, performers and musicians. One to one activities were provided for people who may not be able to join the activities. A guitarist played music for them in their room, staff provided pampering and hand massage and the activities coordinator and an activities assistant spent time with them, using sensory equipment to stimulate their interest. Special days were celebrated such as individual birthdays, the Queen's birthday, National Care Home Day, the Open day of the Olympic games, Valentine's day, Mother and Father's day.

A series of outings was offered to people to reduce any feelings of isolation they may have. The outings and their ways of transport were duplicated to ensure all who wished to participate were able to do so. They included regular visits to the local community centre, going to the forest for ice cream, a visit to 'Bluebell Railway', visiting garden centres and tea rooms, and an outing to see a display of vintage cars and wildfowl. Activities were also provided in the Café on the ground floor to get people out of their usual environment, where they took part in Bingo, quizzes, and 'memory moments'. The High Weald Dementia Support Group hosted weekly sessions in the home's Café, where anyone in the home or in the community with memory problems, and their carers, could gather and gain support from each other.

People, relatives, staff and visitors were given several opportunities to provide their feedback about the service, the staff, the environment, the food, activities and about the running of the service. People's feedback was sought from heads of department every month on their 'resident of the day' day. The head chef also sat with people once a week at lunchtime to update a feedback diary about the food provided; the head housekeeper walked around daily to converse with people and check they were satisfied with aspects of housekeeping. Relatives and people attended 'relatives meetings' every two months that were chaired the registered manager or deputy manager, the clinical lead and all heads of departments. At these

meetings, updates were communicated to relatives about the day to day running of the service and suggestions were listened to and acted on. As a result, laundry staff rota had been increased by eight hours to improve laundry turn-over, and staff had been reminded of the importance to consistently wear their name badge. The head chef had implemented a 'fruit station' on one floor, which was a display of fruit for people to take and eat whenever they wished. As the feedback about this was popular, this was due to be extended to all floors.

Annual satisfaction surveys were carried out by the provider for people, relatives and staff. The survey for people, carried out in April 2016, had highlighted that people wished to have privacy net curtains on some windows, and that a carpet needed to be replaced. This had been implemented. The survey for relatives, carried out in February 2016, showed that relatives wished to gain more practical access to the registered manager as the premises were large and it took them time to locate them. As a result, either the registered manager, the deputy manager of the clinical lead became stationed on each floor so relatives could access a senior manager without delay. The last staff survey, titled 'Over to you', had led to a pay increase for staff.

People and relatives we spoke with were aware of how to make a complaint. Detailed information on how to complain was provided for people in the Residents' guide and displayed in the entrance. One relative said, "I have complained verbally once and the manager has acted straight away to put things right." Thirteen complaints, in written or verbal form, had been made in the last twelve months. They had been investigated and responded to in line with the provider's policies and procedures.

Good

Is the service well-led?

Our findings

People were complimentary about the way the home was run. They told us, "It is definitely well managed, all the staff are very organised and I can always talk with the manager, she is very nice and she spends time to listen" and, "I get on very well with the manager on the floor, she spends time to listen and she gets things done."

The current registered manager had been in post for two years and was on annual leave during our inspection. In their absence the home was managed by the deputy manager and the clinical lead, who were supported by an operations support manager. The operations support manager stepped in to offer support and guidance when a member of the senior management team was on leave. Additionally, a regional clinical lead was available to offer guidance about any clinical issues.

Management responsibilities were clearly defined and relatives were complimentary about the structure of the management team, telling us, "It works well; the manager, the deputy and the clinical lead form a great trio; they have complementary skills, they are well known throughout the home and inspire confidence to the residents; they know what they are doing and are totally approachable", "Since the new manager has stepped in, the home has settled down beautifully", and, "Very good management, very efficient, especially good at communicating with the residents and the families."

Staff were positive about the support they received from the registered manager. They reported that they could approach the registered manager and the management team with concerns and that they were confident that they would be supported. They described them as, "brilliant, lovely, totally supportive", "having an open door policy", "on the ball" and "with a nursing background so they can understand any nursing problem."

The registered manager encouraged the staff to be involved with the running of the service. They held clinical meetings every morning with the nurses and team leaders on duty to discuss any concerns they may have. Every two weeks, meetings were chaired by the registered manager, the deputy manager and the clinical lead for all heads of departments. A general staff meeting where all staff were invited to attend was held every six months. All meetings were recorded and any action that was agreed to be taken was monitored until completion. A member of staff had suggested using coloured plates for people who had sight impairment and this had been implemented.

There was a robust system in place to monitor the quality of the service and drive improvements. The registered manager, deputy manager and clinical lead carried out daily walk-rounds of the premises, taking time to talk with residents and observe staff practice. When any shortfalls were identified, action was taken to remedy them. An unannounced spot check at night had shown that a care worker had not plugged in some sensor mats and disciplinary action had been taken as a result. This system complemented regular audits that were carried out by the management team and designated staff, which included accidents and incidents, weighing charts, medicines, infection control, complaints and satisfaction surveys. When an audit had identified a shortfall, the registered manager checked that an action plan was set up, monitored the

plan until completion and signed it off when satisfactorily completed.

The registered manager participated in monthly meetings with other sister homes in the region to discuss policies, procedures and practice. The provider had established an annual system to regularly gather the views of people, their relatives and staff, analyse the results and act on implementing any improvements that may be identified. Additionally, the provider had commissioned a research organisation that undertook a 'Mystery Shopper' survey where they contacted people's relatives and obtained further feedback about the home. The provider carried out regular unannounced quality assurance visits to the home and produced a report based on the CQC methodology looking at evidence of the service being safe, effective, caring, responsive and well-led. These findings was analysed by the registered manager for action. We looked at the current operation action plan and noted that actions to be taken had been monitored until completion, such as ensuring that staff had attended care planning training.

The registered manager ensured the home maintained links with the local community. A local dementia group came to the home once a month to meet, socialise and gain support from each other. The group included people and their relatives or friends who lived locally and who were affected by living with dementia. The home had opened its doors to the public during the national Care Homes Open Day and a summer fete. At these events, funds had been raised for the Alzheimer's Society charity. The customer relations manager organised regular presentations on subjects such as living with dementia, Parkinson's disease, the effects of a stroke, financial matters and Power of Attorney (POA). Staff displayed posters outside the premises, delivered leaflets and advertised in local newsagents to inform the public of these presentations and other events. The home welcomed volunteers and four volunteers came to the home to chat with people and display flower arrangements. The local Brownies and students from a local school had visited the home and met people who lived there. As people had reported to enjoy their visit, this was planned to become a regular event.

The provider's philosophy of care statement included, "We believe that a good quality of life stems from the ability to take pleasure in the ordinary and familiar things that we do every day and that these simple tasks can be used to promote and support health and well-being." Our observations confirmed staff shared this vision. The deputy manager told us told us, "We strive to provide the best for our residents and make a real difference in their lives. If when I go home I know I have made a person smile then I am content."

The registered manager was open and transparent. They consistently notified the Care Quality Commission of any significant events that affected people or the service. They were fully aware of updates in legislation that affected the service. The service's policies and operating procedures were appropriate for the type of service and clearly summarised, to help staff when they needed to refer to them. They were reviewed on an on-going basis, were up to date with legislation and fully accessible to staff for guidance. Records were kept securely and confidentially. They were archived and disposed as per legal requirements.