Heanton Limited

Heanton Nursing Home

Inspection report

Heanton
Barnstaple
Devon
EX31 4DJ

Tel: 01172872566

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23 July 2018

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Ratings

Overall rating for this service	Outstanding ☆

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?	Outstanding ☆

Summary of findings

Overall summary

This inspection was completed on the 18 and 23 July 2018 and was a planned comprehensive inspection looking at all five key questions. Prior to this, the last inspection was completed as a responsive focussed inspection which took place in March 2018. This was in response to a specific incident of someone swallowing a hazardous substance. The Care Quality Commission (CQC) wanted to ensure people were safe and systems were in place to prevent any further incident occurring. In March 2018 we only looked at the key questions of safe and well-led. We did not identify any areas of concern and the service improved to a rating of overall good.

Heanton is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Heanton accommodates up to 52 people in one adapted building. The service is divided into three separate units which the service calls 'houses' by the name of Watersmeet, Exmoor and Williamson. Williamson is on the ground floor and caters for people living in the earlier stages of dementia. Also on the ground floor is a smaller house - Exmoor. This caters for people with complex needs due to their dementia needs. Upstairs there is one house - Watersmeet for people living with dementia who were in a repetitive stage or advanced stage of their dementia. The provider has developed and implemented this care model based on the household model of care pioneered in the USA by LaVrene Norton, Action Pact and Steve Shields. At the time of the inspection there were 51 people living at the service.

The service had a registered manager. 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.

Staff offered care and support which is exceptionally caring and compassionate. People mattered and staff had a detailed understanding of people's likes, preferences and wishes. People were asked to think of a wish and staff went out of their way to achieve this. Some staff came in on their day off to take people out for trips and meals out. Staff visited people in hospital in the own time, to keep in contact and show they cared. Staff knew people and their families well and worked in a person centred way.

The visions and values were imaginative and people were at the heart of the service. The registered manager and senior leaders led by example. The service was really well led and creative in the way they developed the service. They had developed bespoke training which gave staff the enthusiasm to embrace their vision and values to provide a family and home like environment where people felt safe and loved. This was evident in our observations, in records and in the way staff spoke passionately about people. There were strong links with the local community. The management team looked for ways to ensure people, their family and staff were involved in the running and improvement of the service.

The service was exceptional at helping people to express their views so that all staff understood their views, preferences, wishes and choices. They did this by ensuring staff had the skills to understand and interpret people's complex ways of communicating.

There were sufficient staff with the right skills and understanding of people's needs and wishes. Some concerns had been expressed following the inspection about insufficient staff on duty. The provider was open and honest in identifying there had been times when they had been short on their preferred numbers in the last month or so. However, the provider, registered manager and staff team all agreed that people's needs and safety were not compromised due to staff shortages because of sickness. People and their relatives said staff were exceptionally kind and helpful. Our observations showed staff respected people's dignity and privacy and worked in a way which showed kindness and compassion. This indeed where people were nearing the end of their life.

Care and support was person centred and really well planned. Staff had good training and support to do their job safely and effectively. Activities were tailored to meet individual's needs.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice. People's consent to care and treatment was sought. Staff used the Mental Capacity Act (2005) (MCA) and Deprivation of Liberty Safeguards (DoLS) and understood how these applied to their practice.

Risk assessments were in place for each person. These identified the correct action to take to reduce the risk as much as possible in the least restrictive way. People received their medicines safely and on time most of the time.

Staff understood about abuse and who and when they should report any concerns to. Recruitment practices were robust and ensured only staff who were suitable to work with vulnerable people were employed.

People enjoyed a wide and varied choice of meals. Mealtimes were relaxed and enjoyable for people.

Quality assurance processes and audits helped to ensure that the quality of care and support as well as the environment was closely monitored. This included seeking the views of people and their relatives.

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.

Medicines were safely managed, although we made a recommendation which was actioned around recording topical creams.

People were kept safe because recruitment procedures were robust and staff understood what to do if they had concern around abuse.

The service was staffed at an appropriate level to safely meet people's needs.

The premises and equipment were maintained to keep people safe.

Is the service effective?

Good

The service was effective.

The provider was committed to maintaining a homely environment. This was work in progress and some improvements were needed for some bedrooms and corridors.

Staff received the provider's bespoke training which was based on the provider's model of care and CQC's key line of enquiries. This ensured staff delivered a high standard of individualised care to people.

Staff understood their responsibilities in relation to the Mental Capacity Act (MCA) (2005) and Deprivation of Liberty Safeguards (DoLS). Appropriate applications had been made to the DoLS team and best interest decisions were being made where people lacked capacity.

People were supported to maintain their health and wellbeing and their nutritional needs were well met.

Is the service caring?

Outstanding

The service was exceptionally caring.

People, relatives and professionals all gave glowing accounts of staffs' caring and compassionate attitude.

Individualised care for people was promoted and embedded into everyday practice. They were highly motivated and offered care and support that was exceptionally compassionate and kind.

Staff relationships with people were strong, caring and supportive. Staff spoke confidently about people's specific needs and how they liked to be supported.
Staff showed a real empathy for the people they cared for and treated people like family members.

Is the service responsive?

Good

The service was responsive.

Care plans contained information to help staff support people in a person-centred way and care was delivered in a way that best suited the individual.

Staff were committed to ensuring people experienced end of life care in an individualised and dignified way.

People's social needs were met and they were encouraged to follow their interests.

There were regular opportunities for people and those that mattered to them, to raise issues, concerns and compliments.

Is the service well-led?

Outstanding

The service was exceptionally well led.

The management team established a strong, open and visible culture within the service. They led by example and staff responded by providing high quality care to the people.

Staff and healthcare professionals spoke positively about the management team and how they were developing the new service and including them.

The management and staff teams continuously sought to improve and develop the service. They had bespoke effective quality assurance systems in place to review and assess the quality of service and monitor how it was run.

The views of people using the service, relatives and staff were at the core of quality monitoring and assurance arrangements.

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 18 and 23 July 2018 was unannounced on the first day. The first day of the inspection was completed by two adult social care inspectors, a pharmacist inspector, a specialist advisor in nursing for dementia and an expert by experience. An expert by experience is someone who has had direct experience or their relative had used registered services such as care homes. The lead inspector returned on the second day, which was an agreed date, to review further information and speak with staff.

We looked at all the information available to us prior to the inspection visits. These included notifications sent by the service, any safeguarding alerts and information sent to us from other sources such as healthcare professionals. A notification is information about important events which the service is required to tell us about by law. We also reviewed the service's Provider Information Return (PIR). This is a form that is completed at least annually. It asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection we spoke with 11 people. However, some other people were not able to comment specifically about their care experiences, so 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 living with dementia. We also spoke with six relatives. We spoke in depth to the registered manager, clinical lead, director, three nurses, lead person for induction training, eight care staff, two housekeeping staff, maintenance person, two kitchen staff and the administrator. We received feedback from seven healthcare professionals.

We looked at six care files including risk assessments, care plans and daily records. We reviewed 13 medicines records, three recruitment records and a variety of records relating to the auditing of the environment and quality of care.

Good

Is the service safe?

Our findings

When we looked at this key question at the focussed inspection in March 2018, we did not identify any areas for improvement. The Care Quality Commission was made aware of a person swallowing a harmful substance by an initial phone call to us from the registered manager. At that point they had not appeared to suffer any ill effects. They had been advised by the 111 services to monitor the person for symptoms. The service was advised to send in a statutory notification, which they did. We also advised they ensure the staff member concerned complete further COSHH training which the registered manager agreed they would action.
We looked at the measures in place to protect people from the risk of harm from harmful substances. Following this incident, the service had made some changes to their policy and procedures. This provided assurance that the provider had learnt from the incident and that this learning had been cascaded to staff via meetings, training and written communication. Staff confirmed changes in practice to keep people safe.

At this most recent inspection people were unable to directly comment on whether they felt safe. However, our observations showed people were relaxed in their surroundings, chatted with staff and appeared content and comfortable for most of the time. Where people showed signs of distress due to their dementia, staff were quick to intervene to provide reassurance and comfort so people returned to a calm state quickly. One person died recently and as they fell, they hit their head. This was being reviewed by the coroner. The notification and daily records indicated, they had been checked recently by staff and their fall had occurred with a short time after this.

On the first day of the inspection, we identified some bedrooms upstairs which had a strong odour and had not been cleaned by mid-afternoon. The providers own quality assurance team had completed an unannounced evening visit the evening before our inspection. They identified the same rooms as needed a deep clean and had plans in place to resolve this. Some of the lino floors appeared sticky. We were assured by the provider that this was due to the domestic staff either using too much or too little cleaning fluid. They had already identified this as a training issue. They had organised for the cleaning fluid company to provide training to all domestic staff across their homes within the next month. They had been short of the expected number of housekeeping staff. This was being addressed and a new housekeeping lead was ensuring training and monitoring of the home's infection control and cleanliness was kept up to date.

We identified one corridor where on the first day there was a slight odour, but by the second inspection day, this had become pungent. The provider explained that they had had a cleaning firm in to deep clean this area since our first inspection day, but the cleaning appeared to have exacerbated the smell. The provider agreed to fast track this area to be re-floored within the next week of the inspection being completed. Following the inspection, the provider had updated us to say some of this flooring had been replaced but that some of the corridor required more remedial work and this had delayed the laying down of the rest of the flooring. The taking up of carpet and relaying of new flooring had been risk assessed. We did receive one concern about the flooring being taken up, but was assured by the provider that this was being done in a planned way to keep people safe.

Since the inspection, we have received concerns about corridors not being clean and hygienic. The providers quality assurance team visited unannounced and sent us pictures of the corridors which were clean. The provider had introduced a new head of housekeeping role whose key responsibility was infection control, cleanliness of the building and training to staff. The person doing this role showed enthusiasm and commitment to ensuring that the home was free from odour and cleaned to a high standard. They said there had been some shortfalls in numbers of cleaners but this was being addressed.

At the time of the inspection there were sufficient staff available each shift to meet people's needs. Staff had a good knowledge and understanding of people's needs. They were skilled and caring towards people with complex dementia care needs. The staffing levels were usually set at two nurses per shift, 11 care staff which included two homemakers. This role was specifically to stay in lounge and dining areas to assist people at key times, to eat, drink and remain comfortable. In addition, there was a full-time staff member who completed induction training for staff but who could if required be an additional staff member on the floor when needed. The care staff were divided with two in Exmoor, four in Williamson and five in Watersmeet. This could change and adapt depending on need. The care and nursing staff were supported by housekeeping staff, including three cleaners, two laundry staff and three maintenance staff. There was one cook and one kitchen assistants. There was also a full-time receptionist, as well as the registered manager who was supernumerary to the nursing and care staff.

Following the inspection, we received some information of concern about staffing levels, skills of staff and newer staff not having received their full induction. We liaised with the provider who confirmed there were two days during August when, due to staff sickness, they were unable to cover shifts for the preferred numbers they had assessed as needing. However, they remained confident that people were not placed at risk due to staff sickness and lower staffing levels. The provider stated that in Exmoor the staff member working there had agreed with the nurse that to bring a new member of staff into the house would be more of a risk. They managed the situation by having one of the housekeepers who knew people well in this house, to be based in and around this house. The analysis of incidents showed there were fewer altercations between people than usual on the days they were short staffed. The provider agreed that newer staff who were on induction had been used to help with staffing shortfalls, instead of being supernumerary. Some of these newer staff had not had their full induction. They were used for non-direct care tasks, such as being available in communal areas for assisting people with drinks and eating their snacks and meals. The provider said their induction days would be planned in so they did not miss out on learning and working alongside more experienced staff.

The provider said they had tried to fill sickness gaps with agency staff, but at short notice they were not always able to supply agency staff to assist them. The provider has since signed up with all care agencies in the local area to try to provide a wider range and cover when needed for future. They also have an active recruitment process ongoing. They have completed some analysis of key times when there may be more occurrences of altercations or incidents and have agreed that a second home maker role was needed for the upstairs unit- Watersmeet. They had recruited and were in the process of getting these new staff inducted.

Staff said that there were always the right number of staff rostered to work but that staff calling in sick at short notice had meant there were some key times they may have been short. All staff felt they had worked well as a team and that people's needs were not compromised at any time.

Some healthcare professionals said that although staff were skilled at working with people, they had noted at times that the service appeared short staffed. One said "I regularly visit Heanton nursing home to carry out assessment on behalf of the NHS regarding eligibility for continuing health care (CHC) and their care needs. On visiting Heanton they are always very friendly and open. They allow me access to the clients care

records via their computer system…At times there does seem to be a lack of staff as some of our CHC clients require a 1-1 and at times it can feel a bit chaotic." When we fed this back to the provider, they informed us there were very few people who were funded for additional one to one staffing, but where required for specific things such as personal care, this was provided. A review of people's care notes evidenced that this was provided in a timely way for people.

None had any comments which showed direct impact on people living at the service. Some healthcare professionals had left positive feedback at the service about the skills of staff. These included "Heanton took on a person not normally within their remit, as an emergency to help us out. They have been quick to communicate, share ideas and have been innovative in seeking ways to best care for this person." Another commented: "The gentleman I visit has made amazing progress and is so settled in Exmoor…Staff are so enthusiastic and very creative in their ideas to move things forward and improve well-being. They are now addressing physical health issues that haven't been looked at in years and will have been impacting on behaviours."

People's medicines were generally managed and administered safely, although we have made a recommendation to review the way creams and external items are recorded.

People could look after their own medicines if it had been assessed as safe for them. Nurses or trained staff gave most people their medicines. They had been checked to make sure they gave medicines safely. These staff recorded the administration of medicines on Medicine Administration Record (MAR) charts. A sample of 13 people's MARs showed that people were given their medicines correctly in the way prescribed for them. There were systems in place to record the application of creams and other external preparations, with clear directions for care staff on how and where these should be applied. However, in one house the paper records had not been completed for 3 weeks, as staff told us that they thought these should be completed electronically. Staff told us that they were reviewing the way the use of these products was recorded. We recommend that a more consistent system is used across the home to evidence that these are being used appropriately. Since the inspection the clinical director has sent details of how this was being addressed and monitored.

There were suitable arrangements for ordering, receiving, storing and disposal of medicines, including medicines requiring extra security. Storage temperatures were monitored to make sure that medicines would be safe and effective. There was information about people's individual medicines, and policies available to guide staff on looking after medicines safely. Where medicines were prescribed 'when required' there were protocols in place to guide staff on when it would be appropriate to give a dose. For example, one person prescribed a sedative medicine for severe anxiety had a clear plan listing signs for staff to watch out for, and giving clear details on when and how a dose might need to be given.

Some people were given their medicines disguised in food or drink (covert administration). This was carried out in their best interest following assessment under the Mental Capacity Act. The pharmacist was consulted to check that the proposed method of administration was safe.

There was a reporting system so that any errors or incidents could be followed up and actions taken to prevent them from happening again. There had been a recent issue which we discussed with the registered manager. The incident was being reported appropriately and was still under investigation. We saw that appropriate measures had immediately been put in place to minimise risks. Regular medicines audits were carried out and some actions were identified from these audits to help improve medicines management in the service. The supplying pharmacist also undertook advisory visits and audits, and we saw some

recommendations from their recent visit had been put in place.

All people living at Heanton Nursing Home have been assessed as requiring a safe environment in which to live. This means that access and exit to their "Houses" require being made secure by the use of a key pad system. People were at liberty to move freely within their House and people wishing to go outside of their environment are escorted by staff. We saw people being taken for walks around the grounds, sitting in the entrance hall chatting to staff and spending time in their own rooms. Staff were aware when people became restless and anticipated they may need a change in environment. Each house had communal lounges and kitchens as well as quieter sitting areas where people could spend time.

We observed people being encouraged and supported to be as independent as possible. Care plans contained a number of comprehensive risk assessments and where a risk had been identified there was clear instruction for staff on how to mitigate or minimise the risk. We observed that risk assessments had been regularly updated to reflect the current situation.

The risk assessments contained personalised and thoughtful actions to minimise the risk. For example, one person was considered at risk of falls so staff were asked to ensure the person had well-fitting footwear and to check the footwear for suitability. Where people had been identified as being at risk of developing pressure sores, equipment was in place to prevent this. Risk assessments included instructions to staff about how to minimise this risks with regular checking of vulnerable skin areas as well as regular repositioning of people who were unable to move freely themselves. Where skin was vulnerable or a wound had occurred, body maps and skin care plans were in place and reviewed daily.

Staff understood types of abuse and who and when they should report any concerns to. The service was open and transparent, working closely with the local safeguarding team and commissioning teams. There was a high volume of reported incidents of people showing expressive behaviours and having altercations with each other. However, few serious
incidents where people had been hurt as a result of these altercations. Care plans included instructions for staff about how to redirect people when they became agitated. This might include going out for a walk, moving to a different area and spending time talking with a staff member. We saw these interventions working to good effect during our inspection visits. The lead for safeguarding in Devon County Council gave feedback to show they were satisfied with the way the service had dealt with people's expressed emotions.

Emergencies were planned for. For example, each person an emergency evacuation plan and regular fire safety checks were being done, including testing of alarm bells. Fire equipment such as extinguishers had been serviced and maintained on an annual basis.

People were kept safe because recruitment practices ensured only staff who were assessed and checked as being suitable to work with vulnerable people were employed.

Good

Is the service effective?

Our findings

People were unable to directly comment on whether staff were providing them with effective care and support. Relatives mostly said they were confident staff were skilled and understood people's needs. Comments included "When my relative first came here, I knew it was the right place, staff understood how to care for them. We are very happy with this home. We didn't have the best experience elsewhere." One relative contacted us following the inspection and did not feel the staff understood or were meeting their relative's needs. We asked the local safeguarding team to follow this up. We have received information to show that the service have been and continue to meet the person's needs. However, the relative needed support to understand their family members full diagnosis. The providers quality assurance team and the registered manager have spent time with the relative in assisting them to understand their family members needs and how staff are approaching their care. They have also liaised with healthcare professionals to ensure good partnership working. The commissioning team reviewed this person's care and was satisfied their needs were being met.

Professionals who visited the service gave positive feedback about how staff worked with people effectively. One said "Have visited a patient in the downstairs section. I found staff very approachable, caring and knowledgeable, and I was impressed with the layout/dynamics of the area." Another said about staff in Exmoor "staff had good knowledge of client's needs, clients were treated with respect and dignity."

We received some less positive feedback from a visiting community nurse who felt the a person's needs were not being well met in terms of their physical care and their leg ulcers. When we fed this back to the provider, they could evidence via the person's care plan, that the person had capacity but was frequently resistive to staff interventions around their personal care or having bed rest and keeping his legs elevated.

Whilst some extensive work had been completed to ensure communal areas were dementia friendly, the corridors and some bedrooms were still in need of refurbishment. The provider had acknowledged this and had a programme of refurbishment they were working through. The areas of improvement included the division into three separate houses, kitchens of each house for access by people and staff at any time for drinks and snacks. Also, for more stimulating objects for people to pick up and use. The provider said this was still work in progress and they were looking to include more objects which were of relevance to people living with dementia. One relative said "the environment is reasonable, not perfect, but no nursing home would be. The chairs are comfortable and the team make sure everyone is safe and secure. This is done in an unobtrusive way, even down to the decor. For example, in parts of the home they have wall papered the door to look like a bookcase so that people don't try to use the door." The provider had a planned programme and expected to complete most of the refurbishment work by January 2019.

The provider was committed to providing the right skills and training to staff as they believe this was key to ensuring the most effective service. To this end they had developed bespoke training modules which followed the five key questions CQC look at in depth. These were offered four times per year in addition to the mandatory training in areas of health, safety and understanding the conditions of people they cared for.

Staff had been enthused by this training. One said "In our Bristol training we look at all the care domains and see how best we can meet people's needs. 18 months ago, our interactions with people were not as good. The Bristol training has sorted this, they are our role model. We are also provided with a business update regarding any changes and new introductions, it also gives us a chance to mix with other homes." Another said "we do on line training and this all comes alive when we go up to Bristol every 3 months for face to face training. It has been fantastic and really helped us make sure we focus on people as people."

New staff received a three-day induction plus time to spend with more experienced staff to help them understand the role before becoming part of regular staff on shift. Staff said the induction was comprehensive and covered most aspects of what they needed to know with on the job learning filling the gaps. One newer staff member said, "I was given time to spend with experienced staff, to read up on care plans and to understand their model of care, it's the best induction I have had."

In addition to training, staff said they were well supported with regular meetings and one to one supervisions. These provided staff with opportunities to discuss their role and their learning needs as well as talk about what had worked well. Staff said senior managers, nurses and directors all worked alongside them to model care and support. One said, "When senior staff come to the home, they get stuck in and help if we need it, they don't just sit in the office, they talk to us and our ideas are valued." One of the quality assurance team had been providing one to one time to work with staff in recording their interaction with people. This was face to face and remotely via phone calls. Staff had found this useful and the quality of daily records showed staff had taken this training on board. Staff described people's emotional wellbeing as well as the care tasks they had completed. They also recorded people's 'magic moments'. This may be an observation or an interaction where a person showed delight in something the staff and they were doing. For example, staff had recorded the following for one person "Earlier today x was worrying about not having any money. I then printed out some money and cut it up and put it in a drawer in reception. I asked X if he wanted to come to the bank to get some money, which they did. He said thank you very much not having any money made me panic. I am very happy I have some now. He then went and showed all our family members the money he had. He was very happy."

The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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 decisions, any made on their behalf must be in their best interests and as least restrictive as possible. Where people lacked the mental capacity to make decisions the registered manager and staff followed the principles of the MCA.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals 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.

The Care Quality Commission (CQC) monitors the operation of DoLS and we found the home was meeting these requirements. The registered manager was aware of their responsibilities in relation to DoLS and had made appropriate applications if they needed to restrict a person's liberties. Some of these had been authorised by the DoLS team. Staff had received training on the MCA and they demonstrated an understanding of people's right to make their own decisions.
The registered manager had a checklist of DoLS expiry dates and told us that when a person is admitted to the home she requests an urgent and standard authorisation for DoLS plus a two week extension and then

waits for the authorisation.

We saw a letter had been sent to people's relatives explaining that to fulfil the requirements of the Mental Capacity Act and data protection laws the home needed copies and information regarding Power of Attorneys that are registered. Family members were asked to bring in the original documents so that they could be scanned into the care plan/information system. This letter also asked for relative consent to take photographs to display on the walls of the home to fulfil the aim of creating a homely environment.

People's nutritional and hydration needs were being well met. Throughout the inspection staff were observed offering people a variety of fluids, snacks and meals. Smoothies and drink supplements were available for those requiring high calorific diets. Plates of fresh fruit was offered during the morning and homemade cakes, ice-creams and lollies during the afternoon. Each House has a kitchenette which enables access to food over a 24-hour period.

We observed people being encouraged to eat and drink and supported to be as independent as possible. Catering staff receive the nutritional assessment results so that they were aware of who was losing or gaining weight. This enabled them to fortify food for people who were losing weight. This showed a joined up and effective approach.

Snacks were available throughout the day and main meal menu choices were available in pictorial form to enable people with cognitive or speech impairment to choose what they would like to eat. People's food preferences were detailed in their care plan. Staff knew about people's preferences.

When people were first admitted to the home their food and fluid intake was recorded. This was so that staff could get an idea of when and what they like to eat and drink and if they would need to be encouraged and supported to ensure sufficient nutrition and hydration.

We observed the lunchtime experience, there were tablecloths, jugs of squash on the tables, the pictorial menus, dining chairs with arm supports to enable people to change position easily and due to the hot weather two air conditioning units had been positioned in the dining area to ensure a comfortable environment.

Staff interaction was thoughtful and considered. For example, one person was sat next to a window with the sun shining in and a member of staff asked if they would like the curtain partly drawn while they had their lunch. People were asked if they would like salt and pepper on their food. There was an upbeat and jovial atmosphere with people joining in singing a variety of songs.

Staff clearly knew people's dietary preferences, for example one member of staff told another that a person did not like any vegetables. The food presented looked and smelt appetising and was hot when served.

Staff told us they had received nutrition and hydration training and were able to tell us who was at risk of choking and who had been seen by the speech and language team (SALT) and what the recommendations were.

Outstanding ☆

Is the service caring?

Our findings

The culture, ethos and underpinning training for staff at Heanton ensured people were truly respected as individuals. This was evident in the observations, the records and in the way staff spoke about and with people. Examples of how this worked in practice included:

•Having people express a wish for themselves. Each person was being encouraged to think of something they would really like to do or experience. One person had expressed a wish to eat out at a nice restaurant. Staff were exploring this with them to find the right place. One staff said they would come on their day off to help facilitate this wish.
•Being innovative and creative in reflecting people's histories. Several men enjoyed tinkering with cars and one loved washing cars. The provider had found an old car and named it the Heanton Hooter, which people could sit in, tinker on or wash as and when they wished. This was situated in the front of the home and next to where staff took breaks so interactions were frequent for people using the car.
•Another person enjoyed shopping and items were placed on a shelf for them to collect into a basket as when they wished. Staff spent time talking and encouraging the person to enjoy this activity telling them they were really helping. This made them feel very valued at the home.
•People who lived at Heanton were referred to as family members. One healthcare professional said "Staff afford everyone respect and dignity calling them family members and showing them genuine value and affection. This affords people (who have experienced significant trauma and displacement) a sense of safety they may never have experienced or certainly haven't for a while."
•Staff recorded 'magic moments' for each person to show when their emotional well-being had improved from an interaction. Examples included, "I was massaging x hands for her to get used to me and for feeling her hands, I then asked x if I could support her to cut her nails and she nodded at me, x had dropped off to sleep …she woke up just as I finished and she said they were beautiful and had a tear in her eye which bought a tear to my eye and we had a cuddle x has now falling asleep again in the lounge. Another example of a magic moment was "Came into Williamson House dining room, X asked me for a tea towel and said, "have you seen all this washing up I need to get done?" …X did this for a good 45 minutes and she appeared very content and said, "well someone had to do it, we can't have our house looking like this when visitors are expected can we?"
•The model of having separate houses with kitchens for each area ensured the service was home like. One relative said "Everything is so person centred, the way the team at Heanton treat everyone and the way it tries to make it feel like home is very impressive. It's a place run with real heart." Staff took pride in making people's rooms more personalised. One person loved football and was patriotic. Staff had been out and bought union jack bedding and accessories. When the person saw their room, they had a huge smile and said, "That's handsome!"
•Bespoke training for all staff meant they understood the model of care, treated people as people first rather that a person with a diagnosis of dementia. Staff had a detailed knowledge of what people had enjoyed doing in the past, who and what was important to them and how to provide comfort and reassurance to individuals at different times.

The service ensured that staff in all roles were highly motivated and offered care and support that was

exceptionally compassionate and kind. For example, one healthcare professional said "My person is treated as an individual always, even the housekeeping staff know what he likes and how to communicate with him. This a person-centred service." Another healthcare professional said "Staff have shown a great deal of kindness and compassion to my client. Their needs are not normally what they work with but staff have been working hard to try and understand the person." Staff went above and beyond to show compassion and kindness to people. For example, four staff visited a person who was in hospital in their time off. They took them their favourite things such as chocolate and a motorbike magazine. Two staff came in on the day off to take two people out for a trip to the seaside to enjoy fish and chips by the sea.

The service was exceptional at helping people to express their views so that all staff understood their views, preferences, wishes and choices. They did this by ensuring staff had the skills to understand and interpret people's complex ways of communicating. For example, one staff said "We have been taught that when someone asks for their mum, they are expressing they are distressed in some way and may be seeking reassurance. We say things like, oh I am sure they will be here in a minute, lets you and me have a cuppa and see if we can find something nice to eat, or would you like me to give you a cuddle and chat to them about family and friends."

The service used simple menu cards with pictures to help people make every day choices about what they wished to eat. We saw staff offer two options of meals on plates and wait patiently for a response. Dolls and cuddly toys were used to help provide comfort and a sense of providing care to someone else. One staff member said, "We have quite a few who love to cuddle their baby, talk to them and really gain sense of caring from this." Another person loved dogs and had been given toy dogs to care for complete with feeding bowls and brushes for grooming.

Care plans contained a high level of detail about people's known life histories, preferences and who and what was important to them. Staff had a good understanding about what care plans contained which enabled them to provide care in a person-centred way. Plans and information were used dynamically to help staff communicate with people about things and people they valued. For example, one person was seemingly disengaged and a member of staff asked them if they would like to look at photos of pubs they used to frequent. The person remained engaged and focussed on using the computer to look at images of pubs in the local area. Their sense of engagement and well-being was enhanced, because staff knew what they had previously enjoyed and was able to use this to engage with them in a meaningful way.

The service anticipated people's needs and recognised distress and discomfort at the earliest stage. It offered highly sensitive and respectful support and care. Examples of this were seen throughout the day. For example, staff knew two people were likely to have an altercation if they passed each other, they anticipated their movements and provided support to both individuals to move to an area where they wished to be. When one person became distressed and called out, staff went to them quickly each time, spoke with them about what they wanted and gave them a cuddle and words of reassurance. Interactions between staff and people living at Heanton were spontaneous and caring in their nature. It was clear staff were comfortable in giving people physical comfort when this was needed. One relative said "They always offer mum a cuddle when she is shouting out distressed. I can't think of a more caring home. We are over the moon with the care here. It is a very caring and loving place." One person said "I really like the staff, I don't think there is one of them that isn't friendly. I couldn't choose a better place to be in".

Staff looked for ways to ensure people's privacy and dignity was upheld. For example, one staff member had made customised aprons and shirt fronts to work towards not needing to use traditional clothing protectors for people. This demonstrated a caring and compassionate attempt to provide people with dignity.

The exceptional caring ethos was extended to people's relatives and to staff. One relative had been struggling to accept their family members diagnosis. The staff, registered manager and members of the quality assurance team had spent time talking though the relatives concern. They tried to find a solution to what they wished for, which was to have their family member back home, which sadly wasn't feasible. However, they arranged for the relative to have lifts and spend as much time as they wished with their family member. Staff confirmed that their own well-being was considered important by senior leaders. One staff member said "I have never worked in such a caring environment. Not only are our family members given love and support, staff are too. The manager is good at making sure we are okay. If someone seems down or not themselves, support is offered."

Equality and diversity was celebrated and staff sought ways to ensure this was part of their everyday practice. For example, one person was from a different European country. Staff had talked with their family about ensuring they had the right food and snacks the person would enjoy and were part of their national heritage. They also brought in books about the person's country and encouraged them to talk about their life there. People's relationships with family and friends was encouraged and staff ensured family members were kept up to date with events that had occurred for their relative. Visiting was unrestricted and where there was a concern about the person being at end of life, relatives were made welcome and could stay over.

Good

Is the service responsive?

Our findings

People's care and support was well planned. This was because there were clear care plans which instructed staff how to best support someone with their personal care, emotional and healthcare needs. Staff confirmed they used plans to help them understand people's needs. Plans ensured people had person centred care because it gave good details for staff to understand their likes, dislikes and preferred routines. Staff fed into the care plan process with detailed daily records about what people had been doing, how their needs had been met and how their emotional well-being was. Some relatives said they had not been involved in care planning. The recording of how families were asked to get involved was work in progress. There were not always formal meetings to discuss care plan content, but staff did use information given by friends and family to help inform the care plan. It was clear from plans that relative's contributions had been used to complete life histories. The provider said they had commenced "family member of the day" to be discussed as part of handover. Part of this was to make a call to family to give them a full update on their loved one's progress and to ask them for any feedback or anything that they have observed that they would like to be included in their plan of care.

The provider information return gave good examples of how care plans were being used dynamically. It said "An electronic care planning system has been in place over the last 12 months, the domains in each care plan prompt personalised care planning. We have a care plan guide that staff use when compiling care plans, there are a plethora of prompts within this to encourage staff to think in a personalised way. Families have been involved in the care planning, they have sat with staff to devise and review care plans."

Staff said they found care plans and daily records invaluable when coming in after a few days off. One staff member said "The plans are well set out, you can easily pick up a plan and know what you need to do to work with the family member. When I have been off for a few days I always check back on the daily records to see what people have been up to."

We looked at how the provider complied with the Accessible Information Standard. The Accessible Information Standard is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given. Care plans included where staff needed to consider people's sensory or hearing impairment. Staff could communicate with, and understand each person's requests and changing moods as they were aware of people's known communication preferences. Areas of the service were sign posted with pictures, for example toilets, to help people find their way. Leaflets and brochures were being produced to explain the household model of care in an easy read format.

The provider recognised the importance of social activities and that all activities no matter how small formed an important part of people's lives. These including everyday activities such as washing up, sharing a cup of tea and sitting outside to enjoy the sunshine. Staff were becoming more skilled at recognising what cues people showed when they needed a distraction, some comfort or just some time to be with a person. Staff saw this was an important part of their role and were becoming more skilful at recording these

moments.

To enable people to continue to enjoy their hobbies staff gained a detailed life history. For example, the PIR detailed the following examples. One man enjoyed golf and staff had set up a temporary putting area for him. A group of gentlemen still loved football, they watch matches together on the TV and in the better weather will have a kick around outside with a football. Several ladies can knit. One had knitted all her life, when provided with wool and knitting needles her face lit up, she even taught a staff member how to knit. Another gentleman enjoyed bowls, he had a set in his room and although he no longer had the understanding how to play staff encouraged him to touch them, roll them and talk about them. Another lady liked to embroider, staff encouraged her partner to bring in the piece she was working on before she needed 24hr care. One man loved Star Wars and a member of staff was in the process of organising to take him to the cinema to see the new film.

There were some planned activities which included tea dances, hairdresser, visiting therapy dogs and musical sessions. These were advertised and people's families were welcome to attend with them. There were lots of photos around the home of people enjoying these activities. One staff member had the role of activities organiser, who planned and facilitated external entertainers. However, the providers model of care did not focus on employing individual team members to facilitate 'activities'. The focus within Heanton was on meaningful occupation; this was a core part of each team member's role.

The provider understood the value of music and how this might trigger memories for people. They had purchased a number of headsets that could play a tailored playlist for people. Staff had asked relatives what music and songs each person enjoyed or had been important to them in the past and then compiled individualised playlists. We saw these headsets being used to good effect when people became restless. Several people were sitting listening to their own music playlists in communal areas. Staff said they had been a great addition to the "toolkit to help people feel relaxed."

The provider recognised the importance of ensuring the culture and values of the home embraced people from different community groups. For example, they had arranged Lesbian, Gay, Bisexual, and Transgender (LGBT) training for staff and were adding further details into the provider's comprehensive induction programme and training materials.

End of life care was considered carefully when appropriate. The registered manager stated the home was a 'home for life'. The home had good links with the local hospice. Training had been arranged for staff with the hospice but unfortunately had been cancelled so the registered manager was awaiting details of the next training course available. One person's relative need lots of support to come to terms with their poor prognosis. The service worked sensitively with them and the hospice nurse to try and effect the right care and treatment for the terminally ill person as well as the family member. This included giving them daily lifts to and from their home so they could spend time with their loved one.

Care plans that we looked all contained details of if the person or their family had wanted to discuss end of life wishes and if so these had been detailed. The registered manager told us about a person who wanted their dog with them when they died and this had been achieved.

It was clear from the care plans that this subject was sensitively handled by staff. There was an end of life checklist document that focused on the practicalities as people approach the end of their lives such as medications needed, an end of life care plan in place, is the person or the persons family aware that they are dying, and have spiritual needs been assessed and arrangements implemented.

The provider had a complaints procedure which made people aware of how they could make a complaint. The complaint procedure identified outside agencies people could contact if their complaint was not resolved to their satisfaction. This included the local government ombudsman, local authority and The Care Quality Commission (CQC). There had been no complaints since the last inspection, but a number of relatives had provided feedback, which had been acted upon. This had included arranging meetings with relatives and reviewing care plans. In the main entrance there was also an opportunity for people and visitors to record their views. There were four different leaflets clearly labelled, 'outstanding, thanks, okay and poor' with large emoji faces which depicted a relevant expression. The service had received lots of very positive feedback. One such example was "Staff are doing an excellent job, nice to see an improving environment and residents seemed happy and well cared for."

Outstanding ☆

Is the service well-led?

Our findings

People really benefitted from a service which was truly well-led. People were at the heart of the service and the senior leaders and staff understood the importance of ensuring people received high quality care and compassion at all times. This was achieved via training and support to staff to help them understand the model of care which ensured a person-centred approach. All senior leaders, from the directors, senior nurses and registered manager worked alongside staff to support people in line with best practice. Staff said senior managers were always accessible and one said, "they are excellent role models."

The visions and values were imaginative and people were at the heart of the service. The vision statement for the service was to 'provide the best possible care by attracting like-minded individuals with similar values and beliefs who are able to create emotional relationships with individuals who are living within the home.' We saw many examples of how staff worked to ensure this value statement was embedded in their everyday practice. From using technology such as the wireless headsets to allow people to listen to their own playlist of music which was important to them, to a simple hand massage or cuddle to give someone comfort. Staff were taught not to be task focussed, but to think about the individual, what would make them smile, be engaged and enjoy their day. Staff at every level knew people who lived at the home well. This was because the provider had invested time, resources and training to ensure care plans and records were person centred and used dynamically. Staff were able to use this information to help engage with people about things which were important to them.

Where things had gone wrong, the provider, managers and staff were open and honest about any mistakes made and worked together to find a solution to prevent things going wrong again. For example, there were a high number of incidents of people conflicting with other people within the service, however there were few where this had resulted in any direct harm. Where an injury had occurred as a result of someone else's expressed behaviours, this incident was analysed quickly and care plans and risk assessments updated to alert staff to any measures to prevent future altercations.

There was a registered manager in post who was keen and passionate to promote and improve quality standards. 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 expressed a high level of confidence in the registered manager and directors of the company. Staff said their views and opinions were listened to and there was an open and inclusive atmosphere. Healthcare professionals were complimentary about the registered managers skills and passion for delivering the right care for people. One comment stated "I am confident in Paula's skill as the registered manager at Heanton Nursing Home. She is utterly person focused, and is able to see the person behind the behaviours. She is entirely honest and transparent, even when having to deal with conflicts of opinion, or reticence on behalf of hospital staff. She understands the pressures within the hospital, and how damaging this environment is to the distressed frail patient. I know that I will always have a cheery welcome when I phone Heanton and ask

for Paula, and that however crazy my request seems, that she will listen, and be supportive if she can. Paula inspires confidence in the patients and relatives that I ask her to assess. She is compassionate and very caring. She is open and fair with them, and answers their questions honestly and with integrity. "

The registered manager and director spoke passionately about ensuring they employed staff who fully embraced their ethos, were not afraid to show affection and treat people as "true individuals." One staff member reiterated this when they described their experience. They said "I used to work at another nursing home. Managers there were always like, why are you sitting down just chatting, there are things to be done. When I came here and was told the most important part of my work was to talk to people, I was like wow, this is amazing. I really love coming to work. It isn't about getting everyone up by 10 am, it is about making sure people have choice. They can do what they like and we support them."

Staff were motivated and proud of the service. They wanted to talk to inspectors about what they were doing, share examples of how they worked with people and celebrated people's 'magic moments.' Staff gave up their own time to ensure additional trips out could happen. Staff volunteered to take on champion roles to promote best practice. Staff spoke highly of the bespoke training they were doing with the provider and how this had motivated them to provide high quality care. One staff member said "We are family, we call our residents family members, we take our breaks with family members, we eat with family members, we laugh and cry with family members. It is one big family."

There were consistently high levels of constructive engagement with people and staff and key stakeholders. This was achieved via regular meetings, one to one supervisions, sharing ideas via learning and training. One healthcare professional said "The staff who come to do the assessments are always honest with myself and the team here on the ward and if they feel they cannot meet patient needs then will tell us so. The patients they have accepted have mostly settled at Heanton (I think I can only recall a couple of occasions when the placement failed due to rapid deterioration in Dementia and associated Behavioural and Psychological Symptoms associated with Dementia). Given that there is a lack of provision in terms of Dementia Specialist Homes in the North Devon area for complex and challenging patients, it is good to know that Heanton is there and I feel that I have a good relationship with staff there. The staff at Heanton are willing to talk to the nursing team on the ward and often consider patients that no other Nursing Home would consider. I am aware that Heanton staff have faced challenges in the last few years and, I believe, they have met them head on with a smile and willingness to change where ever necessary."

Governance was taken seriously and well-embedded into the running of the service. There was a strong framework of accountability to monitor performance and risk leading to the delivery of demonstrable quality improvements to the service. The director, quality assurance team and registered manager saw this as a key responsibility. For example, the introduction of electronic records meant the quality assurance team could access records 24 hours per day irrespective of whether they were at the service or not. They had good audits to show that significant improvements had been made to ensuring people's weight was maintained, for example. This had been achieved by ensuring staff understood the importance of accurate recording of people's weights, food and fluid intake and when and how food was being offered. The service had moved away from only offering meals three times per day. These were still offered but there was a constant supply of treats, snacks and drinks to entice people to eat and drink throughout the day. The dining areas were never empty and staff were constantly offering people extra food and fluid. Some professionals had remarked that people were still having breakfast at 10-30 to 11 am. Staff said this was true, because people could have breakfast at any time they liked just like they would in their own home.

The provider's quality assurance team undertook regular visits during office hours and at weekends and

nights. Staff were not always aware that they would be visiting. The system used was designed based on the provider's model of care, key learning messages driven by the provider's vision and values, regulation and compliance, national learning outcomes and best practice innovations i.e. NICE, Infection Prevention Solutions, NHS England. When CQC received concerns, the quality assurance team instigated additional visits unannounced to gain a view about whether the concerns were founded. They were open and honest about the fact there had been certain times they had been short staffed due to sickness, but they were clear people's needs and safety were not compromised. The quality assurance team and registered manager were highly responsive to requests for information when complaints were made. They acknowledged what was working well and what they needed to improve on. They welcomed dialogue with key stakeholders to improve the quality of support they offered. One professional said "They are working with someone who is not within their normal remit, as an emergency placement. They have communicated well, and tried to be innovative in their approach. They have provided the person with another bedroom to use as a lounge and they are working hard to meet the person's needs."

Rigorous and constructive challenge from people who use services, the public and stakeholders was welcomed and seen as a vital way of holding services to account. This was evidenced in the way the senior team recently worked with a relative who had a large number of concerns about the care of their family member. The team worked collaboratively with other key stakeholders including the continuing health care assessor, hospice nurse and GP to try and get the best package of care and support for the person which the relative wanted.

Staff were actively encouraged to discuss any concerns. There were high levels of open engagement when they did so. For example, staff team members discussed when people may need to be considered for a move to another house because their dementia journey had moved on. Staff views and observations were listened to and discussed so the service could facilitate the right move to a different part of the service. Staff were fully consulted on all aspects of refurbishment. The PIR stated 'Staff have training to support confidence in reporting concerns about their colleagues, carers, and other care professionals via their initial induction, induction booklet, online training and offsite safeguarding training. This is reiterated when concerns are raised through handover. We have a 'whole home approach' we learn together and support each other through each stage of our individual and team development.'

The provider, directors, registered manager and staff strove for excellence through consultation, research and reflective practice. The bespoke training which had been developed by the directors asked staff to really think about examples of how they could improve practice through learning from what worked well and what had not worked so well. They had employed a graphic artist to complete a poster on one of their key training days. This was displayed in the hallway for staff to review and reflect upon.

Most people living at the service were unable to express their views about the running of the home. The service understood the importance of ensuring their expressed emotions were used to enhance and develop the service. The staff team looked at negative expressions through the eyes and the position of 'what have we missed' 'what is the person not happy with'. From approaching the review of expressions of behaviour in this manner they were to clearly identify where change and potential improvement in the running of the home is required. For example, this led to an area of the home being refurbished to provide extra living space in one of the houses. Some people could express their views and had influenced the service. For example, the menu choices and sots of activities they wished to do.

A variety of methods were used to gain the feedback of relative's. This included a call 28 days after their family member had been admitted, request for written feedback on forms in the entrance hall, annual

surveys and regular meetings within the home. As a result of relative feedback about not seeing the registered manager as often as they would like, the service moved the office where the registered manager sat, to the entrance hall where viators sign in, so they can see and speak with more frequently.

The service had worked hard to be part of the local community over the last 12 months. For example, Heanton was an active part of the memory café held in Barnstaple. An excellent relationship had been developed with the local church and the facilities of the church had been used for different events for people living in the home, relatives and friends. There had been two very successfully 'tea dance' afternoons within the Church and the Royal Wedding garden party was opened to the local community and for the first-time local people came and said hello! Some people still loved to shop and enjoyed the local facilities within the surrounding area. However, most people owing to their dementia journey and/or their physical health needs were not able to access community life. This is where the service tried hard to get community life coming to them; the local pet therapist, the children from the surrounding schools featured as part of this programme of bringing community life inside. The local riding school brought horses up for people to pet and see. Links had been forged with the local garage. Elderly relatives could go to the garage from the bus stop and the garage would call the home and the service would then arrange to pick them up from the garage to save them having to walk up the steep hill.

The registered manager was meeting their legal obligations such as submitting statutory notifications when certain events, such as a death or injury to a person occurred. They notified the CQC as required and provided additional information promptly when requested. Their most recent CQC rating was displayed in the entrance hall as well as on their website.