

Wigan Council

# Heathside Residential Home

## Inspection report

Heathside Residential Home  
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08 December 2016

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## Ratings

Overall rating for this service

Good ●

Is the service safe?

Good ●

Is the service effective?

Good ●

Is the service caring?

Good ●

Is the service responsive?

Good ●

Is the service well-led?

Good ●

# Summary of findings

## Overall summary

We carried out an unannounced inspection of Heathside Residential Home on 07 and 08 December 2016.

Heathside Residential Home is based in Leigh and is owned by Wigan Council. The home can accommodate up to 30 older people living with a diagnosis of dementia. All bedrooms are single accommodation with 15 providing en-suite facilities. Communal space within the home included two dining rooms, three lounges and a conservatory. A separate hairdressing room is also available. There are two secure central garden areas that are easily accessible from the main building. At the time of the inspection 28 people were living at Heathside Residential Home.

A comprehensive inspection was last carried out at the home on 20 November 2014, when we rated the service as 'requires improvement' overall with one breach of the previous regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, this was because the service did not have effective systems in place to assess and monitor the quality of service provision. A focussed inspection was carried out on 22 July 2015 which looked only at the well-led domain and the previous breach in regulation. At that inspection we found the service had made improvements and was meeting all the legal requirements in relation to the regulations.

At this inspection we found the service was still meeting all regulatory requirements and did not identify any concerns with the care provided to people living at the home. However, we have made two recommendations; these are in regards to ensuring the full completion of assessment documentation and the introduction of a supervisions matrix to assist in monitoring the completion of one to one meetings.

At the time of the inspection the home 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.

We saw the home was clean and had appropriate infection control processes in place. Five domestics were employed, with four working on any one day to ensure the morning, afternoon and evening periods were covered. Cleaning products were signed in and out and checklists were in place to ensure all required cleaning tasks were carried out.

Each person we spoke with told us they felt safe. Relatives expressed no concerns about the safety of their family members and they were complementary about the level of care provided. The home had appropriate safeguarding policies and procedures in place, with detailed instructions on how to report any safeguarding concerns to the local authority. Staff were all trained in safeguarding vulnerable adults and had a good knowledge of how to identify and report any safeguarding or whistleblowing concerns.

We saw the home had systems in place for the safe storage, administration and recording of medicines.

Each person kept their medication in a locked cabinet in their bedroom and only staff authorised to administer medicines were allowed access. All people taking medicines had a medication administration record (MAR) in place, which included a photograph to ensure medicines were given to the correct person. During the inspection all records we observed had been filled out correctly and all medicine amounts tallied.

All staff demonstrated a good knowledge and understanding of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS), which is used when someone needs to be deprived of their liberty in their best interest. We checked whether the service was working within the principles of the MCA. We found that the provider had followed the requirements in DoLS authorisations and related assessments and decisions had been appropriately taken.

Staff spoke positively about the training available. We saw all the staff had completed an induction programme and on-going training was provided to ensure skills and knowledge were up to date.

Staff confirmed they received supervision with their line manager, which along with the completion of team meetings, meant they were supported in their roles. We did note that the frequency of supervisions was different to what was detailed in the service's protocols.

Observations of meal times showed these to be a positive experience, with people being supported to eat where they chose. Staff engaged in conversation with people and encouraged them throughout the meal. We saw nutritional assessments were in place and special dietary needs catered for.

Throughout the inspection we observed positive and appropriate interactions between the staff and people who used the service. Staff were seen to be caring and treated people with kindness, dignity and respect. Both people who used the service and their relatives were complimentary about the quality of the staff and the standard of care received.

We looked at six care files. Not all files contained fully completed pre-admission assessments, which we discussed with the registered manager. Despite this, the care plans contained accurate and detailed information about the people who used the service and how they wished to be cared for. Each file contained detailed care plans and risk assessments, along with a range of personalised information which helped ensure their needs were being met and care they received was person centred.

The home employed an activity champion, who had had a positive impact since commencing employment in January. Everyone we spoke to was positive about the variety and frequency of activities available. We saw the activity schedule catered for all interests and abilities and included involvement from external agencies. A large number of activities and events had been the result of suggestions made from people who used the service. The home actively documented activities and displayed photographs of the different events that had taken place around the building.

The home had a range of systems and procedures in place to monitor the quality and effectiveness of the service. Audits were completed on a weekly and monthly basis and covered a wide range of areas including medication, care files, infection control and the overall provision of care. We saw evidence of action plans being implemented to address any issues found.

## 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.

Staffing levels were appropriate to meet people's needs.

People we spoke with told us they felt safe living at Heathside Residential Home.

Staff were trained in safeguarding procedures and knew how to report concerns.

Medicines were stored, handled and administered safely by staff who had received training and their competency assessed.

### Is the service effective?

Good ●

The service was effective.

Staff reported that sufficient and regular training was provided to enable them to carry out their roles successfully.

All staff spoken to had knowledge of the Mental Capacity Act (MCA 2015) and Deprivation of Liberty Safeguards (DoLS) and the application of these was evidenced in the care plans.

The service worked closely with other professionals and agencies to ensure people's health needs were being met.

Consideration had been given to ensuring the environment was suitable to people living with dementia.

### Is the service caring?

Good ●

The service was caring.

Both people living at the home and their relatives were positive about the care and support provided.

Throughout the inspection we observed positive interactions between staff and people. Staff members were friendly, kind and respectful and took time to listen to what people had to say.

People were able to make choices about their day such as when to get up, what to eat and how to spend their time. Staff had an understanding of the importance of promoting independence.

### Is the service responsive?

Good ●

The service was responsive.

Assessments of people's needs were completed and care plans provided staff with the necessary information to help them support people in a person centred way.

Care plans and other records were regularly reviewed, with involvement from the person themselves, their family or other representative.

People we spoke with were positive about the activity programme at the home. The home provided a varied choice of daily, weekly and monthly activities basing these on people's choices and requests.

### Is the service well-led?

Good ●

The service was well-led.

Audits and monitoring tools were in place and used regularly to assess the quality of the service.

Both the people living at the home, relatives and staff said the home was well-led and managed and they felt supported by management.

Team meetings were held to ensure that all staff had input into the running of the home and made aware of all necessary information.

# Heathside Residential Home

## **Detailed findings**

### Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on 07 and 08 December 2016 and was unannounced.

The inspection team consisted of two adult social care inspectors from the Care Quality Commission (CQC).

Before commencing the inspection we looked at any information we held about the service. This included any notifications that had been received, any complaints, whistleblowing or safeguarding information sent to CQC and the local authority. We also contacted the quality assurance team at Wigan Council.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During the course of the inspection we spoke to the registered manager, six staff members, the activity champion and two visiting professionals. We also spoke to six people who lived at the home and five visiting relatives.

We looked around the home and viewed a variety of documentation and records. This included seven staff files, six care plans, five Medication Administration Record (MAR) charts, policies and procedures and audit documentation.

# Is the service safe?

## Our findings

We asked people who used the service if they felt safe living at Heathside Residential Home. The six people we spoke with all told us they did, with one saying, "I feel safe" and another telling us, "They treat you well." We asked relatives visiting the home for their opinion, one told us, "Yes, I do, [relative] is very safe." Another said, "Totally safe, [relative] seems very happy here." A third told us, "[My relative's] feet would not have touched the floor if I had for one minute felt they were not safe here."

We looked at the home's safeguarding systems and procedures. Safeguarding procedures were in place detailing relevant information about the various signs and indicators of abuse and how to report any concerns. The home had a dedicated safeguarding file which contained a copy of the company policy along with local authority guidance on identifying and reporting safeguarding concerns. This ensured that anyone needing to report a concern could do so successfully.

Staff we spoke with were aware of the different ways a person can experience abuse and were clear about what action they would take if they witnessed or suspected any abusive practice. Each member of staff confirmed they had received training in this area and that this was refreshed within required timeframes. One staff member told us, "Yes, I went to a conference about this. We do refresh the training and safeguarding is spoken about a lot at work." Another said, "I have done the standard safeguarding training and the tier training, I would report any concerns to the manager."

The provider had robust recruitment procedures designed to protect all people who used the service and ensure staff had the necessary skills and experience to meet people's needs. The recruitment process included candidates completing a written application form and attending a face to face interview. We looked at the recruitment records of seven staff members, two of which had been employed in the past year. We found references were obtained and saw evidence that Disclosure and Barring Service (DBS) check information had been sought. The registered manager told us, "The online application system does not allow for gaps in application forms". She added, "We don't take references at face value either. I always ensure I follow any reference up with a telephone call to ensure the validity of the person." This meant the registered manager only employed staff after all the required and essential recruitment checks had been completed.

Upon arrival at the home, we completed a walk round of the building to look at the systems in place to ensure safe infection control practices were maintained. The premises were clean throughout and free from any offensive odours. We saw bathrooms and toilets had been fitted with aids and adaptations to assist people with limited mobility and liquid soap and paper towels were available. The bathrooms were well kept and surfaces were clean and clutter free. Cleaning products were stored safely and Control of Substances Hazardous to Health (COSHH) forms were in place for all the cleaning products in use.

The home completed dependency assessments for all the people who used the service in order to determine the level of need, however did not employ a dependency screening tool to determine the number of staff needed to meet people's needs. We asked the registered manager about staffing levels and

were told that during the day the home ran with six staff, as well as a shift leader and the activity champion. During the night the home was covered by three staff members, one of whom was always a night lead.

We asked what arrangements were in place to cover sickness and holidays. We were told that the registered manager would contact other staff members and any gaps were usually filled this way. The council also had a 'supporting excellence team' who employ mobile care staff. If needed the service would make arrangements to use these staff as a temporary measure; as the service no longer used agency staff. The registered manager told us, "We were using agency staff 12 months ago, but not used any for months now."

As part of the inspection, we asked people who used the service for their views on staffing levels, with all six believing there were enough staff to meet their needs. We also asked visiting relatives for their opinions. One told us, "I am very impressed with staffing; they always have lots of staff about." Another said, "Very often if you hear a bell go off, you see the staff run to respond."

We asked staff for their views on staffing levels and ability to meet people's needs in a timely manner. One told us, "Just got some new staff, much better than what it used to be. Definitely have enough to meet people's needs." Another said, "Yes, during the day we have six staff which is enough to meet needs." A third stated, "Yes, we have enough staff, if we are ever short the office will help out." We asked staff how long people tended to wait for assistance. One told us, "Seconds, if not straight away." A second said, "A minute at most, we are quick at responding and most times will go straight away."

We looked at how accidents and incidents were managed at the home. An accident/incident record book was in place and all relevant information had been documented and appropriate action taken. The registered manager told us that all accidents and incidents were forwarded to the corporate health and safety department at Wigan Council, who analysed the information and linked in with the home to discuss any issues of concern. Post-accident monitoring forms were in place and completed following any accidents, to help detect any after effects from the accident, which may not have been apparent at the time.

Falls management was handled well within the service. People were recognised appropriately when they were deemed 'at risk' of falls with risk assessments in place and referrals made to the relevant agencies when required. People's care files detailed information to enable staff to appropriately and safely support them with their mobility requirements. Falls were tracked and audited for trends and themes.

We looked at the home's safety documentation, to ensure the service was appropriately maintained and safe for residents. Gas and electrical safety certificates were in place and up to date, all hoists and fire equipment were serviced within regulatory timeframes with records evidencing this. Call points, emergency lighting, fire doors and fire extinguishers had all been checked regularly to ensure they were in working order. During the inspection the fire alarm was accidentally set off by workmen. This resulted in an unplanned fire drill and evacuation of the premises. We noted that this was facilitated appropriately by the registered manager and staff, who worked as a team to ensure everyone was promptly yet safely escorted from the building.

We looked at medicines management within the home. Each person's medication was stored in a locked cupboard within their bedroom. Risk assessments had been completed regarding medicines being in people's rooms and the administration of medicines within that environment. We saw the home had detailed policies and procedures in place and a document had been drawn up which staff had signed to confirm they had read and understood the policies and procedures. This document also contained sample signatures for all staff who administered medicines.



Each person had a Medicine Administration Record (MAR) chart in place, which included their photograph, date of birth, GP details and any allergies. Allergy information was also clearly displayed on the inside of each cupboard door. We viewed five MAR charts during the inspection and saw that all prescribed medication had been administered and signed off correctly, with a running balance documented for each medicine. We saw the specimen signature chart tallied with the staff signatures on the MAR charts. We completed stock checks of five people's medicines. All medicines we checked had the correct amount remaining, indicating that all medicines had been administered correctly.

The home had when required medicines (PRN) protocols in place. These explained what the medicine was, the required dose and how often this could be administered, time needed between doses, when the medicine was needed, what it was needed for, if the person was able to tell staff they needed it and if not what signs staff needed to look for along with any potential side effects. This ensured 'as required' medicines were being administered safely and appropriately. Topical medicine charts were also in place, on which staff had documented where on the body creams had been applied.

Some prescription medicines contain drugs that are controlled under the Misuse of Drugs legislation. These medicines are called controlled drugs (CD). We checked the controlled drug (CD) cupboard and saw this was locked with the key stored separately. We checked the stock levels of three people's medicines and saw that these tallied with the CD register. We also noted that all entries were supported by two staff signatures as is required.

Additional stock was stored in a locked cupboard in the medicines room. Stock control sheets were in place to indicate what was located in the store room and what had been transferred to each person's bedroom. All stock within the cupboard was clearly labelled with a defined space allocated to each person. A medication fridge was also present in which medicines that required storing at certain temperatures were kept. Daily fridge temperature monitoring was in place and had been completed consistently.

Staff told us they had received training in medicines and had their competency assessed to make sure they had the required skills and knowledge. One told us, "It's good here. I did the training, and then shadowed experienced staff before being assessed and gradually starting to administer medicines myself. All in all, it was about a six week process."

## Is the service effective?

### Our findings

People living at the home told us they enjoyed the food and were offered refreshments throughout the day. One said, "Oh you get plenty of drinks and food and you can always have more if you want." Relatives were also complimentary about the food with one telling us, "No complaints about the food, seems really good."

People's weight was checked at regular intervals which helped staff to monitor risks of malnutrition and support people with their diet and food intake. People's dietary needs had been considered and were being managed effectively. Food and nutritional assessments and care plans were in place. These explained each person's needs, how to support them with their diet and eating and any associated risks. For those people on a soft diet, advice sheets were in place detailing what they could and couldn't eat. Processes were in place to assess and monitor people's nutritional and hydration needs. Nutritional screening assessments such as the malnutrition universal screening tool (MUST) were used. This is a screening tool which is used to identify people who are at risk of malnutrition. Professional involvement had been sought where necessary, with Speech and Language Therapy (SALT) assessments and correspondence located in care files.

We observed the meal time experience on both days of the inspection and saw that it was positive for people using the service. The home has two dining rooms situated adjacent to each other, either side of the corridor. Prior to each meal we saw the dining tables had been set properly with each one containing napkins, cutlery, condiments and a vase of flowers. The daily menu was located on a large chalk board outside the two dining rooms and was updated prior to each meal. Upon arriving in the dining room, people were supported to sit at the table of their choice and asked if they would like a drink. We saw that everyone was served in a timely manner and dishes were emptied and removed promptly. People were offered a choice of what to eat. On one occasion when a person was unsure if they would like one of the options, the staff member stated, "You can have a taste, if you don't like it I will go and get you something else. If you do, there's enough for you to have seconds if you've got the room." Throughout meal times, staff were observed sitting with people engaging in conversation and discreetly providing feedback and reassurance.

We looked at how the home sought consent from people who lived there. Staff we spoke with had a good understanding of how and why consent should be sought. One told us, "For people with capacity, we ask them. For those that can't we capture their wishes within the care plan and follow this. It's about knowing each resident." Another said, "Ask them, provide choices and build up trust." A third stated, "Have a discussion with the person, get their agreement before you do anything." Each care plan contained consent forms, which covered consent to care and treatment, use of photographs, signing care plans, people accessing their records and had been signed by either the person themselves or their representative. During the inspection we saw staff seeking consent before providing care and support, including knocking on doors and seeking agreement before commencing any transfers or support with mobilising.

The Mental Capacity Act 2005 (MCA) sets out what must be done to make sure that the human rights of people who may lack mental capacity to make decisions are protected. This includes decisions about depriving people of their liberty so that they get the care and treatment they need where there is no less restrictive way of providing this. We asked staff about their understanding of the Mental Capacity Act 2005

(MCA) and Deprivation of Liberty Safeguards (DoLS). All staff confirmed they had received training and had an understanding of both. One told us, "They coincide with each other, DoLS is about depriving somebody of their liberty, and we do training on both of these." Another said, "I have an understanding of these, it was covered in training."

At the time of the inspection, nine people had a DoLS in place. We saw that the registered manager completed a matrix, which detailed when each application had been submitted, date documents received, start date, expiry date, duration and date for review. We saw evidence that action had been taken to chase up outstanding applications, and that all renewal times had been met.

Within people's care files we saw that any potential restrictions had been assessed, using a restrictive practice assessment tool. This had been drawn up with the involvement of the person and/or their relative, the GP, social worker and staff from the home. As was the case during the last comprehensive inspection in November 2014, we noticed people's bedroom doors were locked whenever they were not in their rooms. Capacity assessments had been completed to determine if people had the capacity to decide if they wanted their room locking, if deemed not too, the person's next of kin had been involved. Consent forms had then been drawn up and signed by the person or their next of kin. All had requested that their doors be locked by a staff member, except for one person who requested their own key, so they could lock it themselves. One person told us, "I can go to my bedroom whenever I want. I have to ask the carer to unlock my door but this is my choice. If I had a key I would likely lose it and I don't want to keep it unlocked as people may wander in."

We looked at the staff training documentation. Staff training was monitored via a matrix with each staff member's record detailing what training sessions had been attended along with the date of completion. Records of training completed along with certification was also located in each staff members personnel file.

We asked relatives if they felt staff were well trained. One told us, "Yes, the staff are outstanding." Another said, "Yes, I would say so. They are not aware that we, the relatives, are sometimes watching. You can see the care they give is genuine, all the staff work to the same level."

We asked staff for their opinions on the training provided. One told us, "I did induction training when I started, gave me enough knowledge to do the job, and lasted three full days." Another said, "After doing my induction training, I shadowed existing staff until I had completed manual handling training. They provide plenty of training here." A third stated, "There's lots of training, they try and put you on as much as they can."

We also saw evidence that the Care Certificate was in place at the home. The Care Certificate was officially launched in March 2015 and employers are expected to implement the Care Certificate for all applicable new starters from April 2015.

The staff we spoke with said they received supervision from their line manager. One told us, "Yes we have these and we also have lots of mini supervisions. We work in teams so have lots of chats about this. I think it is brilliant now." Another said, "Yes, they are called 'my time'. I have had two since I started, I find them very useful." A third stated, "Yes, had a couple of these, they tend to be every three to four months."

However we noted that staff supervision, or 'my time' was not always carried out in line with the council's procedural guidance, which stated that 'my time meetings can be held as often as you feel necessary – we suggest a minimum of once every 3 months and a maximum of once a month'. We looked at six staff files and noted that each of these files had gaps of six months or more between supervision dates. In addition to

this we did not see evidence of staff appraisals or 'my time extra' as the service refers to them being completed. Some staff had started the process, by filling out the necessary documentation, but we did not see any completed meetings in the files viewed. We spoke with the registered manager who assured us they would look at this as a matter of priority.

We recommend that the service implements a supervision matrix, to ensure that all staff are completing 'my time' meetings in line with the council's procedural guidance.

Observations showed that consideration had been given to ensuring the environment was dementia friendly. Bathrooms contained contrasting hand rails, to make them easier to identify. Hand rails on all the corridor walls were also in a contrasting colour for the same purpose. Lighting throughout was bright and consistent, minimising the number of shadows and the flooring in bedrooms and corridors was plain and neutral in colour. We saw that the home had large easy to read signage to indicate the lounges, dining rooms, toilets and bathrooms; including pictorial signs to direct people to where each bathroom was located.

One of the lounges was named the memory lane lounge and contained old fashioned décor and reminiscence items. On one of the corridors a 'bus stop' area had been created, with a bus stop sign and timetable present along with a wooden bench. The walls surrounding the area had been painted to resemble shops and trees. This provided a place for people to sit and chat. During the inspection we saw that people were free to wander throughout the communal areas of the home, and many who did so, stopped at this point to sit for a while. Each corridor was named after a local area or landmark with the sign also indicating the bedroom numbers on that corridor, for example, 'Hilton Park Way 1 – 10'. People using the service had been involved in deciding the names of each corridor as well as the names of the lounge and dining areas.

We saw that people had the opportunity to personalise the plaque on their room door. Some had chosen to just use a name and number whilst others had put up photographs.

Our review of people's care records showed the service worked closely with other professionals and agencies to meet people's health needs, these included general practitioners (GP's), speech and language therapists (SALT) and district nurses (DN's). We spoke to two visiting professionals who told us that the service was really good at chasing things up, and communication was excellent. We were told that at present no-one using the service had any pressure areas; however staff were proactive at linking in if they had any concerns, such as when a potential pressure area was developing.

## Is the service caring?

### Our findings

The people we spoke with told us they liked the staff and found them to be caring. One told us, "The carers are very nice. They are just ordinary and will do anything for you." Another said, "They treat you well." Whilst a third stated, "When I am feeling miserable the staff will cheer me up." We spoke to visiting relatives to get their views, one said to us, "I can't fault the care, we feel very lucky to have [relative] here." A second said, "Often when I visit, the staff are sat talking with my [relative], it's lovely to see." Whilst a third added, "I feel so relieved my [relative] has come here. It is a big weight of my shoulders to know she is cared for like she is."

We asked people who lived at the home if staff treated them with dignity and respect. All confirmed that they did. Relatives also told us that this was the case, with one saying, "I cannot speak highly enough of the staff." Another told us that, "Oh yes, they are very respectful. They often hold [relatives] hand when walking, give them a cuddle, the staff are always smiling." We asked the staff how they maintained people's dignity and respect. One said, "This starts from getting up, knock on their door, ask them what they would like, talk to them." Another told us, "It's about their rights and choices. Keep them covered up when washing; explain what you are going to do. I treat people how I would want my family to be treated."

Whilst speaking to staff we asked them how well they knew the people they cared for and how they knew what they wanted. One told us, "When they first come in we ask them or their family what they would like. We listen to people; observe them and their reactions to things." Another said, "I talk to them, document their wishes in the care file. If they can't verbalise I will speak to their family." A third stated, "Through having a chat with people they tell me, I talk to people and find out what they like. One lady loves reading so I recently took her to the shop to get some magazines." A relative we spoke to told us, "My [relative] loves rugby. The home arranged for two of the local rugby players to visit her at the home, she was then taken for a tour of the ground, she loved it."

As part of the festive celebrations each person had been asked to 'make a wish' for Christmas, with their wishes recorded on a paper star which had been displayed on the wall. Where possible staff were supporting these to come true, through arranging pamper days, trips to local garden centres amongst other things. One person had said they hadn't had 'spanish' for a long time, and the home had purchased a box of old fashioned liquorice for them.

Over the course of the inspection we spent time observing the care provided in all areas of the home. People looked clean, appropriately dressed and well groomed. One relative we spoke to told us, "My [relative] is always well spruced when I visit and this is every day." We saw staff interaction with people was warm and friendly. For example staff members were observed ensuring they were at eye level with people when engaging in conversation, even if this involved bending or kneeling down. Appropriate physical contact by the staff was observed, such as hand holding or placing their arm around someone whilst speaking discreetly with them. Throughout the inspection people responded positively to the interactions with staff and care being given. This was commented upon in feedback from relatives, with one telling us, "My [relative] is extremely happy here. They are always smiling." Another said, "[Relative] is very happy here, you can see in their demeanour."

The staff we spoke with displayed an awareness and understanding of how to promote people's independence. One said, "I let them do as much as they can for themselves, if they can wash themselves I let them but make sure they know I am here if needed." Another told us, "I get people involved in doing things for themselves such as brushing their teeth and hair, getting their laundry box, folding their clothes and putting them away, I help them but encourage them to be independent."

The care files we viewed contained an equality and diversity profile which covered marital status, ethnic group, religion and sexual orientation. The profile also contained a section for people to record any special requests or requirements they had such as cultural or religious wishes and needs.

People's end of life care was dealt with in a sensitive way. When appropriate, people had documentation in place to ensure their end of life wishes were considered. This included decisions around resuscitation. We saw compliments from families thanking the service for the care and support offered to them when facing the final days of their loved ones lives.

## Is the service responsive?

### Our findings

We saw that people received care that was personalised and responsive to their individual needs and preferences. Prior to any new admission a pre-assessment was carried out with the person and their relative(s). However we noted that the assessment documentation in five of the six care files we viewed was only partially completed. Despite this each care plan was extremely detailed and captured people's support needs and wishes so that staff knew exactly how each person wanted to be cared for.

We recommend the service ensures pre-admission documentation is fully completed as part of the assessment process.

Each person had two files in use, a main care file, which contained comprehensive assessments and care plans and what the service called 'a bedroom file', due to where it was stored, which contained a brief overview of all care plans along with details of how to support that person. Each bedroom file contained an 'about me' document which provided information on areas such as the person's emotions, what makes them feel comfortable, favorite food and drink and how they like to spend their day. There was also a 'what's important to me' document in place, which included details of where and how the person wanted to be supported. Both of these documents had been used to formulate the care plans for each person and provided guidelines for staff on the provision of care.

We also saw evidence of a person centred approach within the main care files. Assessments had been completed in a range of areas including communication, memory and understanding, hygiene and personal care, family contact and social company. In each instance people had been asked to state what they preferred, what they were able to do, what they needed assistance with and what was important to them in that area. Each document then explained how the service intended to meet those needs.

During conversations with family members we were told of two instances where the service had been responsive to a person's individual needs and wishes. One relative told us, "My [relative] is getting more frail and finding it harder to get about, without asking they found them a room nearer to the lounge and dining area, so they didn't have as far to walk." Another said, "They asked me what my [relative's] most favourite thing was. I told them and they are now arranging it for me. Now that's amazing."

People we spoke with could not remember whether they had been involved in planning or reviewing their care. However one relative told us, "I was involved in the initial assessment, they asked me lots of questions." Another said, "I can request to see the care plan whenever I wish." Whilst a third stated, "Care plan reviews are frequent, I am aware of everything." We saw records of family involvement in both initial care planning and reviews of care plans, with formal reviews taking place every three months or sooner if any issues of note or major changes had arisen. Additionally staff members reviewed each person's needs on a weekly basis documenting if any changes had occurred.

We asked staff how they knew what was important to the people they cared for. One told us, "It's written in the care plan, information from families, getting to know each person, what they tell you, their body

language and expressions." Another said, "Talk to them, spend time getting to know them and read their care file."

The bedroom file also contained a daily diary, which was used by staff to record what each person had done that day, their mood and general presentation and food/drink information. The file also contained a bath/shower chart which was used to record personal hygiene information. We noted that whilst these had been filled out consistently, where a person had refused the offer of a bath or shower on their chosen day, the chart did not indicate whether an alternative had been offered and carried out, such as a full body wash.

The home employed an activity champion, who was responsible for organising and facilitating the activity programme. We spoke to this person who told us that when anybody new comes into the home, they meet with them and complete an activity profile. This includes recording their likes and dislikes and making decisions about things they would like to try. Over time the profile is developed to include each person's needs and abilities and what things they have enjoyed and would like to do more of. Each person also has a daily activity sheet, which captures what they have participated in. We saw the activity files which evidenced this documentation was in place and completed consistently.

An activity board was located close to the lounge and dining area detailing the activities for that week along with upcoming activities and events. We saw that a range of activities and events had been organised for over the Christmas period including visits by two local choirs, a pianist and the home was hosting a 'Strictly comes to Heathside' evening, which the people we spoke with said they were looking forward to.

The home had a four week activity programme in operation; this had been requested by people using the service and subsequently implemented. Activities were scheduled for 10 – 12, 2- 4 and 18.30 – 20.00 each day. Examples of things on offer included, gardening, art and craft, ball games, hand and nail care, parachute and domestication sessions. External agencies also visited the home to provide activities including twice monthly 'sensorial' sessions, aromatherapy and a monthly tea dance, during which a room was set up like an old fashioned dance hall, and people took part in sing along, dance and movement. Some people at the home had indicated they missed visiting the seaside and so were asked what their main memories of the seaside were. In response to this the home had held a 'donkey day', which included decorating the home, bringing in a donkey which people could touch and stroke and serving up fish and chips and ice cream, these being all of the things people remembered from trips to the seaside.

Relatives provided us with positive feedback on the activities available. One told us, "They do a lot of memory stuff here, which I am happy about." Another said, "The activities they have here are brilliant. [Activity champion] has got a good rapport with everyone."

We looked at how complaints were handled. The service had policies and procedures in place to deal with formal complaints. The policy provided directions on making a complaint and how it would be managed, this included timescales for responses. The registered manager told us the service had not received any formal complaints in the past year. We noted the provider also ensured processes were in place to capture any daily minor complaints. Both staff handbooks and service user guides detailed how to make a complaint and what to expect throughout the process. People we spoke with were knowledgeable about what to do if they had any concerns and felt confident these would be dealt with effectively. Likewise comments from family members/visitors supported this.

The registered manager held a file which contained compliments cards, letters and emails. We noted the service had received 11 compliments in the past year; these were from other professionals and family members. We looked at a sample of these and noted positive comments which complemented staff on their



professionalism, and the service for the standard of care received by their family members. One letter said, "To all the staff, we cannot put into words how much we appreciate all the love and care you gave to our relative."

## Is the service well-led?

### Our findings

At the time of our inspection there was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like the registered provider, they are Registered Persons. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The home had a clear management structure in place. Each shift was overseen by a lead support, who in turn received support from a shift leader as well as the registered manager. The lead provider manager for Wigan Council was also present on the first day of inspection and we were told there was a regular presence in the home.

The staff we spoke with felt that the home was well-led and managed and they felt supported. One told us, "Yes, I really enjoy working here; you're made to feel part of a team." Another said, "I enjoy my job and 100% feel supported." Both the registered manager and the shift leaders were reported to be visible on the floor, one staff member said to us, "They are too visible, it seems like they are always there watching. I'm only joking, but seriously they are all really nice and very approachable." One of the relatives we spoke with told us, "The management are very helpful. You can approach the manager with anything and she will deal with things well." Another said, "I am really pleased with how the home is developing. The manager is doing all they can. My [relative] is secure and happy."

Staff and relatives told us there was a positive culture within the home. Comments included, "brilliant atmosphere", "good working environment" and "there's a good atmosphere here. Staff are very friendly and welcoming."

We saw that team meetings were completed both separately with each designation of staff and also with the whole staff team. Meetings were scheduled to take place at least every six months, although we saw records that indicated full staff meetings had taken place in February, June and December, with individual team meetings held in October. Ground rules had been set up and agreed for all the meetings, to ensure they ran effectively and everyone was able to participate. We saw that minutes had been taken and action plans generated.

The home's policies and procedures were stored electronically and included key policies on medicines, safeguarding, MCA, DoLS, moving and handling and dementia care. Policies were updated at corporate level and the home notified of any changes; this meant that the most up to date copy was always available and staff made aware of any changes to practice.

The home used a range of systems to assess the quality of the service, this included the inclusion of people using the service and their relatives by sending out, 'consultation questionnaires'. The registered manager told us that the consultation questionnaire was sent out three times per year and was designed to look at people's view on the home's response to complaints, people's satisfaction with the décor, the attitude and approachability of staff, as well as asking for feedback on what they could do better and what people would

like to see and do. We looked at 20 of the relative questionnaires and noted all the responses indicated people were happy with the service provided. We saw that resident questionnaires included an easy read and pictorial version to ensure the inclusion of each person. We looked at 15 which had been returned and noted each person had commented they were happy and had no complaints in any area.

Meetings were also held with people and their relatives on a four monthly basis, in order to provide information about the home but also to receive feedback on performance and discuss any issues or concerns. We saw that meetings had been held in February, July and November with minutes taken and circulated.

The home had introduced a 'you said, we did' board, which was used to report on people's requests and feedback, including those recorded on the consultation questionnaires and from the resident/relative meetings. We saw that people had asked for a four week activity programme, an Elvis tribute night, a rock and roll tea dance, new street signs and brighter décor. Feedback about what the service had done was recorded and we also saw the points had been actioned and implemented.

We saw systems in place to monitor the quality of the service. The registered manager told us the provider employed a quality performance team. This team was responsible for carrying out audits and analysing areas such as falls, accidents/incidents and safeguarding alerts. The registered manager said she would be alerted by the team of any trends and themes that may require further follow up or investigation.

Internally the home completed a range of audits covering all aspects of home maintenance and service provision. Handyperson audits were carried out weekly looking at lighting, general maintenance, cleanliness and condition of furniture and equipment. Domestic and environmental audits were also completed to ensure walls, floors, furnishings throughout the home were in good condition, clean and free from stains. Other areas audited on either a weekly or monthly basis included meal times, mattresses, infection control, care plans and medication. All audits contained actions points along with information about what had been done to address any issues.