

Pearl Care (Norwich) Limited

Heatherside Care Home

Inspection report

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Date of inspection visit:
13 March 2017
14 March 2017

Date of publication:
16 May 2017

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?	Requires Improvement ●
Is the service well-led?	Good ●

Summary of findings

Overall summary

This inspection was unannounced and took place on the 13 and 14 March 2017. This was a comprehensive inspection completed to check the provider's progress in meeting the requirements required as a result of our last inspection on 6, 20 and 21 September 2016. At that inspection we found the provider had breached four regulations associated with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (HSCA 2014). These related to the following regulations, Regulation 9, (Person centred care), Regulation 12 (Safe care and treatment), Regulation 18 (Staffing) and Regulation 17 (Good governance). The provider was served with a warning notice in relation to good governance which they were required to meet by 1 February 2017. We told the provider they needed to take action to meet all their legal requirements and we received a report setting out the action they would take to meet the regulations.

At this inspection we found improvements had been made in relation to all the requirements of the regulations identified however more time was needed to ensure people were receiving the social interaction and stimulation they required to lead interesting, full and meaningful lives.

Heatherside Care Home (referred to as Heatherside throughout this report) is a care home which provides residential care for up to 34 older people living with a range of medical conditions including Parkinson's disease, diabetes and those living with sensory loss and dementia.

The home is situated in a village on the outskirts of Basingstoke. It comprises two floors, is situated within its own grounds and has a two acre secure rear garden. The home has 32 rooms, a communal lounge with a large television and doors leading through to a patio area and the grounds. There is a smaller quieter and more private seating area adjacent to the main lounge. There is also a dining room, bathroom and shower rooms and a lift for access to the first floor. Meals were served according to people's choice in their rooms or dining room. At the time of the inspection 28 people were living at the home. Throughout this report care staff will be referred to as 'staff'.

Heatherside does not have a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission (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. The home's current manager was in the process of becoming registered with the CQC.

People using the service told us they felt safe. Staff understood and followed guidance to enable them to recognise and address any safeguarding concerns about people. People's safety was promoted because risks that may cause them harm had been identified and guidance provided to staff to help manage these appropriately.

People were supported by sufficient numbers of staff to meet their needs. The provider used a staffing tool to assess people's dependency to identify the numbers of staff required in order to meet those needs.

Recruitment procedures were fully completed to ensure people were protected from the employment of unsuitable staff.

People received their medicines safely, staff had received the appropriate training to enable them to complete their role safely. Where people received medicines in a way other than prescribed by the GP advice had been sought and followed by the appropriate healthcare professionals to ensure it remained safe to be administered by an alternative method such as crushing for example.

Contingency plans were in place to ensure the safe delivery of people's care in the event of adverse situations such as a fire, flood or utilities loss. These were easily accessible to staff and emergency personnel such as the fire service, if required to ensure people received continuity of care in the event of an on-going adverse situation which meant the home was uninhabitable.

People were supported to eat and drink safely whilst maintaining their dignity and independence. We saw that people were able to choose their meals and were offered alternative meal choices where required. People's food and drink preferences were documented in their care plans and were understood by staff. People were supported to eat and drink enough to maintain a balanced diet.

Care plans and risk assessments contained detailed information to assist staff to provide care in a manner that respected each person's individual requirements and promoted their dignity. People were encouraged and supported by staff to make choices about their care including how they spent their day in the home.

People received care which was regularly reviewed to ensure contained the most up to date guidance for staff on how to effectively meet people's needs. Care plans and risk assessments were reviewed monthly to ensure they remained accurate to enable staff to meet people's needs.

People, where possible, were supported by staff to make their own decisions. Staff were able to demonstrate that they complied with the requirements of the Mental Capacity Act 2005 when supporting people. This involved making decisions in the best interests of people who lacked the capacity to make a specific decision for themselves. Staff sought people's consent before delivering their care and support.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The manager showed an understanding of what constituted a deprivation of a person's liberty and was able to discuss the processes required in order to ensure people were not deprived of their liberty without legal authority.

People told us that care was delivered by kind and caring staff who sought to meet their needs and ensure they were happy. We saw that people had friendly and relaxed relationships with staff who would stop and speak with them when they had the opportunity to do so.

People living with specific health conditions such as diabetes for example were supported to manage these conditions safely. Guidance regarding the management and monitoring of people's blood glucose levels was sought and we saw this guidance was followed in practice.

Work was ongoing to ensure people were provided with the opportunity to participate in activities allowing them to live interesting and fulfilling lives. During this inspection people told us they felt there was a lack of opportunities for them to be able to participate in activities of their choice. The manager was already aware of people's feelings and was taking positive action to address these appropriately.

People and relatives we spoke with knew how to complain and told us they would do so if required. One complaint had been made since the last inspection and effective procedures to monitor, investigate and respond were followed by the manager in an effective way. People and relatives were encouraged to provide feedback on the quality of the service through a number of quality control questionnaires.

The manager promoted a culture which focused on people receiving care in a relaxing environment. Staff, people and relatives felt the home had a homely and happy environment. Staff felt supported by their colleagues and the management team.

The manager had informed the CQC of notifiable incidents which occurred at the service allowing the CQC to monitor that appropriate action was taken to keep people safe.

The quality of the service provided was reviewed regularly by means of effective quality control audits. These were completed to identify areas where the quality of the service provided could be improved. We could see action had been taken to address where any shortfalls in the service provision had been identified.

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.

People were safeguarded from the risk of abuse. Staff were trained in safeguarding, understood how to protect people from abuse and knew how to report any concerns.

Risks to people had been identified and detailed. Recorded guidance was provided for staff and reviewed monthly to ensure people's needs were managed safely

People were supported by sufficient numbers of staff to be able to meet their needs in a timely fashion. There was a robust recruitment process in place to ensure staff had undergone thorough and relevant pre-employment checks prior to commencing their role.

Medicines were administered safely by senior staff who received training appropriate to their role to ensure medicines were stored, administered, documented and disposed of safely.

Is the service effective?

Good 

The service was not always effective.

People were supported by staff who completed a nationally recognised induction process to ensure they had the skills and knowledge required to meet people's needs in an effective way.

People were supported by staff who were not always able to discuss the principles of the MCA however demonstrated a detailed awareness of how to enable and support people to make choices in their daily lives.

The manager was in the process of reviewing people's capacity to make choices around the care they received to ensure that they were supported by best interest decisions.

People were encouraged to participate fully in mealtimes to ensure they ate and drank sufficiently to maintain their health and wellbeing.

People were supported to seek healthcare professional advice were required in order to monitor, manage and treat their changing health needs.

Is the service caring?

Good ●

The service was caring.

Staff were kind and caring in their approach with people, supporting them in a kind and sensitive manner.

Staff had a well-developed understanding of people and had developed companionable and friendly relationships with them.

Where possible people were encouraged to assist in creating their own personal care plans to ensure their individual needs and preferences were known and provided by staff.

People received care which was respectful of their right to privacy and maintained their dignity at all times.

Is the service responsive?

Requires Improvement ●

The service was not always responsive.

People's needs had been appropriately assessed by the manager prior to moving into the home.

The provider was taking action to ensure people were provided with opportunities to participate in meaningful activities to ensure they lived an active and enjoyable life. More time was needed to ensure this action was successful in increasing the quality of people's daily lives.

Processes were in place to record, investigate and respond to complaints received. People felt able to approach the manager and staff if required to raise a concern however had not had the need to do so

Is the service well-led?

Good ●

The service was well led.

The manager promoted a culture which placed an emphasis on creating a homely and relaxed environment which was known by staff.

The manager had informed the Care Quality Commission about

important and significant events at the home allowing monitoring to confirm that appropriate action was being taken where required.

The provider sought feedback from people and their relatives and regularly monitored the quality of the service provided in order to ensure its continuous improvement.

Heatherside Care 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 the 13 and 14 March 2017 and was unannounced. The inspection was conducted by three inspectors, a specialist advisor and an Expert by Experience.

A Specialist Advisor is someone who has specific knowledge, experience and understanding of a particular aspect of care. The Specialist Advisor was a pharmacist who had experience and knowledge of dispensing medicines, inspecting in a hospital environment and auditing medicines in a care home environment. The Specialist Advisor observed a medicines round, reviewed people's care plans, medicines administration records and spoke with staff to ensure people's health needs were being met.

An Expert by Experience is a person who has personal experience of using or caring for someone who use this type of care service; on this occasion they had experience of family who had received residential care. The Expert by Experience spoke with people using the service, a relative, a member of staff, observed a mealtime sitting and interactions between staff and people living at the home.

Before our inspection we looked at previous inspection reports and notifications received by the Care Quality Commission (CQC). A notification is information about important events which the service is required to send us by law.

During the inspection we spoke with 10 people, two relatives and staff including three senior care staff, three care staff, administrative staff, the chef, activities co-ordinator, deputy manager and the manager. We reviewed care documentation relating to 12 people's care and two of their associated daily care notes, five staff recruitment files, staff training records, and 28 medicine administration records. We also looked at staff rotas dated from 6 February 2017 to 13 March 2017, policies and procedures relating to the running of the service, maintenance records, quality survey results and service improvement plans. We spent time observing staff interactions with people which included lunch time sittings.

Is the service safe?

Our findings

At our last inspection of the service in September 2016 we found the provider had not ensured that sufficient numbers of staff were deployed to be able to meet people's needs safely, which was a breach of Regulation 18 (Staffing). The provider had also not ensured that people were receiving their medicines safely, which was a breach of Regulation 12 (Safe care and treatment).

Following the last inspection the provider submitted an action plan which stated they would meet the requirements of Regulations 18 and 12 by 1 February 2017. At this inspection we found the provider had met the requirements of Regulations 12 and 18.

The manager had addressed previous sickness concerns at the home which had necessitated the use of regular agency staff. However immediately before the inspection two members of staff had left their position which meant agency staff were again being used at the home. Rotas identified that the provider was maintaining staffing levels to meet the identified needs of the people using the service.

All the people we spoke with told us they felt that staff were around to help them when they requested assistance by use of their call bells however sometimes had to wait to receive support during the day. One person told us they occasionally had to wait for support in the morning to get ready for the day saying, "You have to wait (for staff) but that's ok". However they said that staff were quick to respond to their needs when they used their call bell to request assistance saying, "I have a buzzer, they (staff) come quite quickly". Another person told us, "I'd like to go out and walk round the patio, you ask if anyone is free to take you for a walk but they're not often free, it's just luck". A relative told us, "I do (think there are enough staff) yes".

Staff we spoke with told us they felt there were not always enough staff available to be able to meet everybody's needs. This was noticeable when staff called in sick at short notice and agency were not in a position to cover to provide assistance. However staff were able to confirm that care was being delivered although it would be delayed on occasions. One member of staff told us, "The staffing during the week is ok but it's worse at the weekends when people tend to go off sick, the manager gets agency staff in but sometimes they let you down, we really struggle then. Nothing is missed but we have to work really hard." Another member of staff told us, "Depending on what the mornings are like we don't have as many staff in but it is getting better".

Following our last inspection the manager had introduced monthly staffing dependency assessments. These assessments identified people's level of needs in a number of key areas including their mobility, continence and sociability. These were reviewed monthly and clearly identified whether or not people's needs had increased which allowed for additional staffing to be provided.

Where concerns had been raised regarding people's level of needs increasing at certain times of the day the manager had sought professional healthcare advice to ensure the home was able to meet their needs. For example, Sundowning is a term used to describe a range of behaviours that people living with dementia can often exhibit in the late afternoon or early evening. These behaviours can include an increase in people's

level of restfulness leading to wandering or become more agitated with mood swings and confusion. People exhibiting these behaviours are at an increased risk of causing harm to themselves such as falling. Where it had been identified people were exhibiting these behaviours staff were required to provide additional support to keep them safe. This required staff being present in areas where these people were prone to wandering. Staff told us this had increased the workload for the remaining staff members who were not in the public areas providing care to people. However this was being addressed by the management who were seeking professional healthcare assessments for these people to identify any additional needs. One member of staff told us, "(with sundowning) we need to have one person where they are but you're then spread so thinly for the other residents". This member of staff continued they were aware of action the manager was taking to assess these people's needs.

Safe staff recruitment procedures were followed by the provider to ensure people were supported by staff with appropriate experience and who were of suitable character. Staff had undergone detailed recruitment checks as part of their application process and these were documented. These records included evidence of good conduct from previous employers in the health and social care environment. Recruitment checks also included a Disclosure and Barring Service (DBS) check. The DBS helps employers make safer recruitment decisions and helps prevent the employment of staff who may be unsuitable to work with people who use care services. The provider had ensured that safe and effective recruitment procedures were followed when employing new staff.

During our previous inspection we could not see that people were always receiving their medicines safely. Arrangements in place for the safe storage, administration and disposal of medicines were not always being followed and guidance had not always been provided to staff on when it was appropriate to give them medicines prescribed 'as required'. These include medicines which are not given routinely such as some analgesics. Documentation relating to creams which had been prescribed for topical application such as creams to prevent skin deterioration or breakdown did not always record that they had been administered as prescribed. The provider had also not ensured that when medicines were given in a way other than the way they were prescribed such as crushing for example, that the appropriate healthcare professional advice had been documented. This was required to ensure that the process of changing the format of the medicines did not affect their effectiveness.

Following the inspection the manager had invited a local pharmacy to complete a full audit at the home to ensure areas for improvement in the way medicines were managed were identified. This had resulted in positive action being taken to address the areas which required improvement. At this inspection we saw that medicines were stored appropriately with fridge temperatures being monitored to ensure they remained safe for the storage of medicines. People were seen to be receiving their topical medicines such as creams as prescribed. Controlled Drugs (CDs) are particular medicines which require additional controls in the way they are handled to ensure people remain safe. At this inspection we saw that CDs were documented, stored, disposed of and documented appropriately. People who received 'as required medicines' had protocols in place to ensure staff knew when it was appropriate to provide people with these medicines. We saw guidance had been sought from healthcare professionals to ensure staff were aware how to safely administer medicines in a way which they had not prescribed, such as crushing, to assist people at risk of choking for example. We saw that directions were provided in this person's care plan regarding the action to take to administer safely however the authority to do so was not clear in their care plan or medicine administration records (MARS). This authority was stored on the manager's computer however all staff knew the action to take in order to ensure this person received their medicines safely.

Risks to people's overall health and wellbeing were identified and guidance provided to mitigate the risk of harm to them. People's care plans included their assessed areas of risk. These included risks associated with

people mobilising, risks regarding people's ability to eat and drink safely and risks regarding people's ability to communicate effectively. Risk assessments included information about action to be taken by staff to minimise the possibility of harm occurring to people. For example, some people living at the home were at risk of suffering from injury whilst mobilising around the home. Information in people's care plans provided guidance for staff about how to support people safely to move around the home. Staff understood these risks and we saw this guidance was followed by staff.

Care plans and risk assessments were reviewed monthly to ensure they remained accurate, appropriate and provided the most up to date information to help staff support people safely. Following the last inspection the deputy manager and manager had rewritten all of the care plans and risk assessments to ensure they contained the information required to allow staff to provide safe care.

People were protected from the risk of harm because there were contingency plans in place in the event of an untoward event such as accommodation loss due to fire or flood. In this event people would be moved to another local residential home or a hotel which was situated in close proximity to the home. These plans provided a quick reference for staff and emergency personnel such as the fire service, of the actions to take in the event of evacuation to ensure continuity of care for people living in the home.

People told us they felt safe which was confirmed by relatives. One person told us "Yes, (I feel) really safe, you can leave your door open day and night". Relatives said they felt their family members were safe, one relative said, "In here (family member) is safe, someone is looking after her".

Staff demonstrated their awareness of what actions and behaviours would constitute abuse and provided examples of the types of abuse people could experience. Staff were knowledgeable about their responsibilities when reporting safeguarding concerns. A safeguarding alert is a concern, suspicion or allegation of potential abuse or harm or neglect which is raised by anybody working with people in a social care setting. All staff felt confident that the manager would act promptly and effectively in response to any concerns raised. People were protected from the risks of abuse because staff understood the signs of abuse and the actions they should take if they identified these.

Is the service effective?

Our findings

At our last inspection of the service in September 2016 we found the provider had not done all that was reasonably practicable to mitigate any risks to the health of people living with diabetes. This had been a breach of Regulation 12 (Safe care and treatment). The provider had also not ensured that requirements of the Mental Capacity Act 2005 (MCA) were followed when supporting people with their decision making process. This had been a breach of Regulation 9 (Person centred care).

Following the last inspection the provider submitted an action plan which stated they would meet the requirements of Regulation 12 and Regulation 9 by 1 February 2017. At this inspection we found the provider had made improvements in relation to meeting the legal requirements.

At this inspection we saw the provider had made improvements in documenting and recording of information for people living with diabetes. Documentation was in place which clearly showed correspondence between the home and healthcare professionals in relation to changes in people's insulin when required. Blood glucose levels were being obtained in accordance with healthcare professional guidance and these were being monitored appropriately. For example, guidance in people's care plans identified a person's normal blood glucose level range. This allowed for staff to identify when people were experiencing high or low levels which if left untreated could have a significant impact on a person's health and wellbeing. Where it had been identified that a person's blood glucose level was not in their regular range we could see immediate action had been taken by staff. This included seeking professional health care advice and support and taking the necessary action to prevent the person's health deteriorating.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

At this inspection we checked whether the service was working within the principles of the MCA and whether any conditions on any authorisations to deprive a person of their liberty were being met. Documentation showed the manager displayed an understanding of when a DoLS would be required and appropriate applications and authorisations were in place where required.

Staff were not always able to clearly identify the principles of the MCA however people told us and staff demonstrated that they complied effectively with the MCA by offering people choices with their day to day care.

The manager and deputy manager had rewritten and were reviewing all people's care plans monthly to ensure they remained relevant and contained the most up to date information required by staff to provide the most appropriate care. As part of this process people's ability to make decisions were also being

assessed to identify if people needed additional support in order to make these decisions. We saw that for new assessments on people's abilities to make decisions the requirements of the MCA and best interest process had been followed fully.

The manager and deputy manager were in the process of reviewing people existing MCA assessments and best interest decisions to ensure they remained valid and did not require a further review. We saw examples where people had been assessed as not being able to give consent to any aspect of their personal care. Where this had been identified the manager had completed the appropriate MCA assessment and held best interest meetings with relevant others including appropriate family members to ensure that the home was able to meet people needs. We could see appropriate support had been sought including external health care professionals such as district nurses and the GP in this decision making process to ensure care provided was in people's best interests.

People and relatives we spoke with were positive about the ability of staff to meet people's care needs. Staff told us they felt they received the necessary training to enable them to conduct their role effectively. One person told us, "On the whole (staff are) very good, I think they are all very good". One relative told us "Yes definitely (staff are sufficiently skilled and experienced), very much so, very impressed."

The provider ensured new staff were in the process of completing an induction which was based on the Care Certificate. This is a structured induction programme staff which ensures staff are sufficiently supported, skilled and assessed as competent to conduct their role and meet the needs of the people they support. Staff spoke positively on whether they received sufficient training in order to meet people's needs. One member of staff told us, "It's very good, there is a lot of training about", another member of staff said, "The manager is very keen on training, it's not a problem". The provider identified that staff were expected to complete training in a number of key areas in order to deliver care, this included first aid, safeguarding, food hygiene, health and safety, moving and handling, fire training and equality and diversity. This mandatory training was required to be refreshed annually to ensure staff knowledge remained current. The provider also sought to provide staff with specific training to be able to best meet the needs of the people they supported, this included providing training in dementia, palliative care and equality and diversity". Staff were also being supported to obtain a nationally recognised qualification in Health and Social Care. We could see a number of staff had successfully completed this training. People were supported by staff who were receiving the necessary and relevant training in order to be able to meet their individual needs.

People were assisted by staff who received guidance and support in their role. There was a structured and documented process in place to ensure staff received their supervision and appraisals within the provider's identified timescale. Supervisions and appraisals are processes which offer support, assurance and learning to help support staff to develop in their role.

People were supported to eat and drink enough to maintain a balanced diet. We saw that people were offered a choice of menu at their mealtimes. The food was currently provided on a four week rolling menu offering a variety of choice at each meal sitting. People ate well and were provided with sufficient time to eat their meals at their own pace. We could see that when required guidance had been documented regarding the type of meals people required or the additional support that they needed to eat independently, this was followed by staff. For example, some people required their food to be provided in specific ways to meet their needs, such as in a pureed form, this was provided. This enabled people to eat independently without any additional support from staff. Most people told us they liked the food which was provided and were involved in making decisions about menu choices. One person told us, "In the week it's very good but it's a different chef at the weekend... it's got better". The chef was in the process of producing photographic images of each menu choice to enable people to be able to see the options available to them. This enables people living

with dementia who may be experiencing associated memory loss to identify the choice of food they require. The chef and manager had also produced a feedback form asking people to express whether or not they wished to have any alternative menu choices available at each sitting including cheesy muffins, poached egg on toast and crumpets at breakfast, lamb and mint pie, lasagne and beef and mushroom pie at lunch. People's preferences were then going to be incorporated into future menu options.

People were supported to maintain good health and could access health care services when needed. Records showed that, when required, additional healthcare support was requested by staff. We saw that people were referred to community nursing teams when appropriate, such as when concerns had been raised regarding people's ability to manage their Parkinson's disease effectively.

Healthcare professional advice was documented and communicated to staff. This enabled health plans to be followed and for people to receive the care they required to maintain good health. We could see for example that appropriate healthcare support had been sought from the community nurses and the GP's. For example we saw one person living at the home was suffering from a pressure ulcer. Documentation evidenced this had been recorded clearly when the first area of red skin was identified and a body map had been completed identifying to staff where the area of concern was. This information allows staff to pay additional attention to this area of risk when delivering care. Advice had been sought from the district nurses and a care plan and risk assessment was in place documenting the action to be taken to keep this area safe to minimise the risk of further deterioration. We also saw people's blood glucose levels were managed safely and when required appropriate and timely advice was sought, recorded and followed by staff to maintain people's health and wellbeing.

Is the service caring?

Our findings

People told us they liked living at Heatherside and we could see they experienced friendly and comfortable relationships with staff. People said that they received caring support from all staff. One person told us, "(the staff are) Lovely, very nice...they're very helpful lovely girls". Another person said, "They (staff) are very helpful, they couldn't do more". A relative we spoke with confirmed that staff had a kind and caring approach telling us, "Very (caring), really a lot, (I feel quite) strongly actually".

Staff were knowledgeable about people and spoke fondly of those they were supporting. The development of these positive relationships had been supported by people's care plans which had been written in a person centred way. Person centred is a way of ensuring that care is focused on the needs and wishes of the individual. Care plans had been written in conjunction with people and their families where possible to ensure they contained highly individualised information regarding people's personal histories and life stories as well as what was important to them.

People's care plans included information about what support they required and when. The details contained within these care plans accompanied by the staff's relationships with people allowed staff to tell us about people's preferred activities, personal care needs and any particular diet they required.

All staff in the home took time to engage and listen to people. People were treated with dignity as staff spoke to and communicated with them at a pace which was appropriate for them. Staff allowed people time to process what was being discussed and gave them time to respond appropriately. We saw supportive and positive interactions between people and all staff. This included engaging people in friendly conversation whilst staff continued their daily tasks. All staff treated people with respect and showed genuine interest for people's wellbeing.

We saw kind and caring interactions between staff and people throughout the inspection. People who were distressed or upset were supported by staff who could recognise and respond appropriately to their needs. Staff knew how to comfort people in distress which included offering physical contact such as stroking people's arms and holding people's hands until they settled. Despite being busy all staff demonstrated that they recognised the support people required with their emotional needs and could offer them additional time and support when needed.

People were supported to express their views and, where possible, be involved in making decisions about their care and support. Care staff were able to explain how they supported people to express their views and to make decisions about their day to day care. This included enabling people to have choices about what they would like to eat or how they would like to spend their day. Attention to appearance was important to people and staff respecting this by assisting them to ensure they were well dressed, clean and had their personal appearance maintained.

People were treated with respect and had their privacy maintained at all times. Records were kept securely in a locked cabinet to protect confidentiality; however these were easily available to staff to review as

required. During the inspection staff were responsive and sensitive to people's individual needs, whilst promoting their independence and dignity. Staff were able to provide examples of how they respected people's dignity and treated people with compassion. This included allowing people additional time with tasks they could complete independently whilst remaining vigilant to their needs and providing people's personal care with their doors shut. We saw staff knocked on people's doors awaiting a positive response before entering.

Is the service responsive?

Our findings

At the last inspection we identified that the provider had not always provided suitable opportunities for people to participate in activities to meet their social and emotional wellbeing needs. This was a breach of Regulation 9 (Person Centred Care) HSCA. We could see steps had been taken to improve the activities available to people to participate in at the home however more time was needed to ensure this action was successful in increasing the quality of people's daily lives.

Immediately following our last inspection a new member of activities staff had been employed in order to provide entertainment both morning and afternoon, five days a week for people living at the home. However during the inspection people told us they did not feel they were always provided with the opportunity to participate in activities which they enjoyed. One person told us, "We used to have bingo and exercise, everyone loved it, but now it's only word searches...we used to do exercise", another person said, "Nothing happens here, it's so boring. There's a word search or painting, we're not kids, we are grown-ups...when I first came 2 years ago we used to do things and make things".

The manager was aware of people's feedback and immediately prior to the inspection had sought people's opinions regarding the activities which they were provided with. This was to ensure that people were able to identify activities which met their individual needs and preferences. This activities questionnaire asked people to identify which activities they enjoyed, such as bingo, singers, exercises and reminiscence for example and what activities they would like to see included in the current activities programme. This included dancers, art to music, a knitting club, a Pets at Therapy Dog who visited people living at the home, gardening and asked people to provide any additional activities they would like to participate in. The questionnaire also asked people when they would like to participate in their activities during the day and which days of the week would best suit people's needs. As a result of the initial feedback received the manager was in the process of recruiting an alternative activities coordinator who would be supported by activities coordinators from a local home which had been rated outstanding due to their activities programme. External training courses were also being sought with support from a social care professional from a local hospice to ensure activities provided were stimulating and enjoyed by all. The provider had taken steps to meet the requirements of the regulations however more time was needed to ensure that the new changes were able to meet people's individual needs.

Peoples care plans contained detailed information regarding people's social and interactive needs to support staff in identifying the care and support they required to make sure their risk of social isolation were minimised. For example one person's care plan stated that they preferred to stay in their room due to their anxiety. It was documented that encouragement was needed to prevent this person from suffering self-isolation whilst maintaining their right to choose how they spend their day. Guidance was provided to staff on how to offer reassurance to this person to see if they would be willing to participate in any activities and the success of this was reviewed monthly. Another person's care plan documented they liked to spend most of their daily sleeping however when activities were occurring they wished to be involved and snakes and ladders was their favourite activity. During the inspection we could see a lively game of snakes and ladders being played in the bright lounge and this person was participating happily. One person's care plan

identified that they were quite shy and reserved and was not sure of the activities they wished to participate in. External groups had been brought to the home to visit this person regularly to encourage their growth of confidence and build up their social wellbeing. Through discussions with this person it had been identified that they used to enjoy photography and as a result the home were going to provide this person with a camera to take pictures of the garden which they enjoyed. The manager was working to seek person centred activities to meet people's social interaction needs.

People and relatives we spoke with told us the staff took time to know who they were and address them as individuals. Not all the people we spoke with said they were engaged in creating their care plans. However we could see where people were unable or unwilling to contribute, relatives had the opportunity to contribute to the assessment and planning of the care required. Care plans provided guidance to staff on the importance of promoting people's independence and we could see this was being followed.

People received consistent care and support. People's care needs had been assessed and documented by the manager before they started receiving care. These assessments were undertaken to identify people's support needs and care plans were developed outlining how these needs were to be met.

Care plans were reviewed monthly to ensure they contained the most up to date guidance to enable staff to provide the most appropriate care. The manager had put plans in place to ensure these would be completed by the newly identified key worker for each individual which was a process which was going to happen immediately following the inspection. A key worker is an individual who works closely with a person living at the home and is responsible for updating care plans to ensure they provide the correct guidance for other staff when delivering care. Care plans and risk assessments were routinely reviewed however were also updated whenever a change in need was identified. One person's care plan had been updated as a result of their increasing support needs and documented the additional actions to be taken by staff to support them with all aspects of their personal care. This had been documented and updated accordingly and information passed to staff during their handover process.

People were confident they could speak to staff or the manager to address any concerns they wished to raise and the manager ensured people were confident to do so. One person told us, "We had a letter the other day saying, any problems, speak to someone you can trust". Processes were in place so complaints received could be recorded, raised with the manager, investigated and responded to. The provider's complaints policy and procedures were clearly displayed in communal areas of the home. This contained information on how people could complain and the action they could seek if the complaint were not resolved within the home. This included contacting the local government ombudsman and the care quality commission if required.

There had been one official complaint received since the last inspection which related to an issue regarding communication. We could see that the resulting investigation had been completed fully with actions taken to address the cause of the complaint to minimise the risk of a recurrence. The manager had written to the relevant parties to apologise under the duty of candour regulations and had also devised an action plan to prevent further issues. The intention of the duty of candour regulations is to ensure that providers are open and honest with people who use services and any other relevant persons in relation to care and treatment. It sets out specific requirements that providers must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong. Where required disciplinary action had also been taken to ensure any risk of a repeat incident were minimised. People we spoke with told us they knew how to make a complaint and felt able to do so if required.

Is the service well-led?

Our findings

People and relatives said they were happy overall with the quality of the service although not all the people living at the home were able to identify who the manager was. Staff told us they felt the home was well led and were well supported by their manager and colleagues.

The manager was keen to promote a service which made Heatherside feel like people's home as much as possible. The manager told us they wanted the home to be a warm, relaxing and cosy place where people and staff felt like they were at home. The provider had a mission statement clearly displayed in the home which was a written set of values and expectations that people could experience whilst living at Heatherside. These included; staff would provide the highest standards of residential care in a warm and homely environment, people's needs would be identified and addressed on an individual basis, staff would be encouraged to develop their expertise in care provision to meet people's needs, the provider would commit to supporting staff and that focus would always remain on people living in the home and care would be delivered to the highest standard.

Staff were able to demonstrate they knew the provider's mission statement and the values of the manager who wanted the home to be open, honest and to feel like a home and not a workplace. One member of staff told us of the provider's values, "It's to provide a home from home", another member of staff said, "It's a family orientated place and that's the ethos that Heatherside tries to have it's a homely place everybody's welcome and gets listened to". The atmosphere in the home was a positive one and was evidenced by the friendly interactions of all staff with the people they supported before, during and after care delivery. A relative spoke positively of the atmosphere at the home and told us, "It's lovely, like I say, homely".

The manager promoted an 'open door' policy and was available to people, relatives and staff whenever required. Whilst people may not have always been able to immediately recognise the manager those who did spoke positively of them. One person told us, "I don't know her name, she's very nice". We received positive feedback from staff regarding the support they felt they received from the manager. One member of staff told us, "They do listen and will respond to concerns", another member of staff said, "The manager is ok, I can say things and they will respond...they do listen, it's a lot better than it was, I was thinking of leaving but I will stay now". People, relatives and staff felt comfortable speaking openly and honestly with staff and the manager who they were confident would address their concerns.

Services that provide health and social care to people are required to inform the Care Quality Commission (CQC), of important events that happen in the service. We use this information to monitor the service and ensure they responded appropriately to keep people safe. The manager had submitted notifications to the CQC in an appropriate and timely manner in line with CQC guidance. The manager had also kept the CQC updated with action plans following their last inspection. This evidenced open and transparent communication from the provider and a commitment to improve.

At our previous inspection the provider had not always ensured there was an effective system in place to monitor the quality of the service people received. There were no regular and detailed quality assurance

audits in place. Since the last inspection the provider had implemented a clear system of quality assurance processes and audits which were required to be completed on a regular basis. These included monthly, bi-monthly and yearly audits which were required in order to assess and maintain the quality of the service provided. In order to continue to drive improvement at the home the manager had also sought external companies to complete independent audits identifying ways the home could improve. For example following our previous inspection the manager invited a pharmacy company to complete a full audit of medicines management at the home. This had been repeated a month later where improvements had been noted and again in January to see if the required improvements had been made. We could see at this inspection that there had been an improvement in the managing of medicines since our last inspection.

On a monthly basis the manager was responsible for completing a number of audits which were used to inform the provider where improvements in the quality of the service provided were required. For example the manager would document the number of people with pressure ulcers and these would be investigated to see why they developed, where they developed and if appropriate care plans and risk assessments were in place. This assisted the manager in identifying whether or not there was a pattern in pressure ulcers developing and whether any preventative action could be taken. People also had their weight monitored each month to ensure they remained an appropriate weight to maintain their health and wellbeing. It had been identified between January and February 2017 that one person had lost a large amount of weight. This weight loss was identified at the earliest stage and action put in place to monitor and treat accordingly. As soon as this loss had been noted we could see the home had sought advice from the person's GP regarding the implementation of fortified drinks to support weight gain and the person's family had been informed.

In addition to the monthly reports the provider also completed audits on all areas of the home and aligned to the CQCs key lines of enquiry which ask whether a service is safe, effective, caring, responsive and well led. During these processes shortfalls, where identified, were documented on an action plan with a deadline for completion and the name of the person responsible for ensuring completion. It was noted in an audit dated 13th February 2017 that MCA and best interest decisions must be completed and placed in relevant sections of people's care plans. This was provided with an immediate deadline and we could see that these had and continued to be in the process of being completed at the time of the inspection.

The provider was keen to seek people and relatives experiences and sought information on how they could improve the service they received. This allowed for improvements in the service provided and was evidenced by the positive feedback which was received. Feedback was sought from people during care plan reviews, residents and relatives meetings which were due to be held every 12 weeks following the inspection. The home also used an online questionnaire which was displayed in the home's foyer which people, family and visitors were able to complete anonymously if preferred. This was an independent national care home survey which allowed people to submit their levels of satisfaction on a service in a number of areas. These include people being treated with dignity, the overall standard of the home, quality of the care staff and management. One review had been submitted online since the last inspection in September 2016. This read, 'Since my mother moved to Heatherside Care Home in January she has been treated with the utmost kindness and respect by the staff all of whom have made her very welcome. My mother becomes very confused at times and the staff have been gentle, patient and supportive in dealing with some of these challenging moments, I would highly recommend Heatherside'.

The provider also requested people and their family completed questionnaires documenting their feedback on the quality of the care required. The last questionnaire had been completed in November 2016. 10 people had returned forms and all expressed a high degree of satisfaction with the provider, particularly in the areas of staff attitudes and quality of care. People we spoke with also spoke positively about the quality of the service provided at Heatherside, one person told us, "I love being here", another person said It's very

nice, very comfortable, all the staff are very fair" with another person saying, "The caring is very good".