Life Style Care (2011) plc

Heritage Care Centre

Inspection report

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Ratings

Overall rating for this service	**Good**
Is the service safe?	**Good**
Is the service effective?	**Good**
Is the service caring?	**Good**
Is the service responsive?	**Good**
Is the service well-led?	**Outstanding** ☆

Overall summary

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 and to pilot a new inspection process being introduced by the Care Quality Commission (CQC) which looks at the overall quality of the service.

There was a registered manager at the service at the time of our inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider.

Heritage Care Centre is a care home for up to 72 people requiring nursing or personal care. It is split over three floors and has separate units for people with dementia. The ground floor has two elderly units, Cavell and Dalton. The first floor has two dementia units, Franciscan and Rectory. Each unit has a unit manager overseeing the care needs for people using the service. The third floor

Summary of findings

has a sensory room, hairdressing room, the laundry and staff room. There is an outdoor space for people to enjoy. All bedrooms are single occupancy with ensuite facilities. At the time of our inspection there were 68 people living at the home.

The home was welcoming, in an excellent state of repair and had a clean, airy smell. People using the service were happy and settled. They told us they felt safe, enjoyed living at the home and were treated well by staff. They complimented the food and told us that staff respected their wishes, including any religious or cultural needs. People were able to leave the home if they wanted, unless staff felt it was unsafe to do so. The provider followed appropriate guidance on Deprivation of Liberty Safeguards (DoLS), carried out risk assessments and involved people or their next of kin when making decisions which restricted people's movements.

Care records were updated by staff on a regular basis. The wishes of people using the service and their next of kin were recorded and taken into consideration when delivering care. Healthcare professionals such as GPs and community nurses were involved in people's care and provided guidance for staff at the home.

Staff were familiar with the needs of people using the service. We observed staff interacting with people in a friendly, relaxed manner. Staff understood what was meant by treating people with dignity and respect. A range of group and individual activities were available for people. We observed some of these taking place and saw that people were engaged and enjoyed them.

The home was managed well and staff told us they felt valued. Training that was relevant to the work that staff were doing was provided and regular staff supervision took place.

The provider followed best practice guidance when delivering care. The management team strove for excellence by following best practice and worked in partnership with other organisations to make sure they were providing a high quality service for people.

Summary of findings

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 told us they felt safe living at the home. Policies and procedures were in place to keep people safe from avoidable harm and staff followed these procedures. Risk assessments for people were up to date and reviewed regularly.

Where people's liberty had been restricted for their own safety, the provider followed appropriate guidance in line with the requirements of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards and took these decisions with the involvement of people and their relatives.

There were sufficient staff on duty to meet people's needs. Where required, extra care workers were made available to meet the needs of people, for example, if they needed to attend hospital appointments.

Is the service effective?

Good

The service was effective. Staff received support and training that allowed them to care for people effectively. Training that was relevant to their role was provided and regular staff supervision took place.

People were provided with sufficient amounts to eat and drink. Staff followed guidance when planning meals to ensure people were given a balanced diet. People were supported by staff whilst eating or drinking if required.

The provider had established good links with community healthcare services so that people received ongoing healthcare support. Healthcare professionals such as GP's, community nurses and speech and a language therapist visited the service and provided specialist advice to support people.

Is the service caring?

Good

The service was caring. Staff were familiar with the people's needs and we saw examples during our inspection of staff showing a caring and respectful attitude to people using the service. People's religious and cultural needs were met.

The home had achieved the Gold Standard Framework (GSF) in End of Life Care. Staff supported people who were at the end of their life in a sensitive manner.

Some staff at the home were dignity champions which was promoted and encouraged throughout the home. People told us they were treated with dignity and respect.

Is the service responsive?

Good

The service was responsive. People using the service told us that staff were responsive to their needs. People or their relatives were involved in developing their care records and their wishes were taken into consideration when delivering care.

Summary of findings

The provider had an effective way of listening to people's views or concerns. This was done through informal meetings involving people using the service, relatives meetings, and informal social gatherings. There was a more formal complaints process that staff were familiar with. Complaints were responded to in a timely manner and the provider used complaints to try and improve the service.

Is the service well-led?

Outstanding 

The service was well led. People using the service, relatives, and staff spoke highly of the manager and the way the home was run. Staff felt supported and said there was an open culture at the home. They said they would not hesitate to raise any concerns if they had any.

Regular meetings and audits were carried out at the home to continuously monitor the service.

The management team strove for excellence by implementing best practice and worked in partnership with other organisations to make sure they were providing a high quality service for people.

Heritage Care Centre

Detailed findings

Background to this inspection

We inspected Heritage Care Centre on 7 August 2014. This was an unannounced inspection which meant the staff and provider did not know we would be visiting. The inspection was led by an inspector who was accompanied by a specialist advisor and an expert by experience . The specialist advisor had experience of nursing care. The expert had experience of older people's care services.

Before we visited the home we checked the information that we held about the service including notifications sent to us informing us of significant events that occurred at the service, and any safeguarding alerts raised. The provider also 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. The service met the regulations we inspected at their last inspection which took place on 9 January 2014.

During our inspection we observed how the staff interacted with people who used the service. We looked at how people were supported during their lunch. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We also reviewed twelve care records, staff training records, and records relating to the management of the service such as audits and policies.

We spoke with nine people who used the service and four relatives who were visiting on the day of the inspection. We also spoke with the registered manager, the regional manager, the activities co-ordinator, kitchen staff and eight care workers. We contacted healthcare professionals involved in caring for people who used the service, including social workers, speech and language therapists and physiotherapists.

This report was written during the testing phase of our new approach to regulating adult social care services. After this testing phase, inspection of consent to care and treatment, restraint, and practice under the Mental Capacity Act 2005 (MCA) was moved from the key question 'Is the service safe?' to 'Is the service effective?'

The ratings for this location were awarded in October 2014. They can be directly compared with any other service we have rated since then, including in relation to consent, restraint, and the MCA under the 'Effective' section. Our written findings in relation to these topics, however, can be read in the 'Is the service safe' sections of this report.

Good

Is the service safe?

Our findings

People using the service told us that they felt safe living at the home and that staff looked out for their safety. One person told us, "I feel safe, everyone is nice." Relatives told us they were "not worried" about the safety of their relatives living at the home.

We found that the home had procedures in place to protect people from abuse and avoidable harm, and staff were familiar with these procedures. Training records showed that 89% of staff had attended safeguarding training within the past year. We saw records of appropriate referrals of concerns to local safeguarding teams and management plans being followed. This showed that the provider followed their procedures for reporting concerns.

We found the provider to be meeting the requirements of the Deprivation of Liberty Safeguards (DoLS). Staff had completed training in the Mental Capacity Act 2005 and DoLS training in June 2014. Staff were aware of what may constitute a restriction on people's liberty and under what circumstances they would apply for a DoLS authorisation. Capacity assessments were completed by staff for people and some applications to restrict people's movement had been made to the local authority where it was deemed that people did not understand risks to their safety and wellbeing. We looked at one person's records and it contained the appropriate documentation relating to a DoLS application.

People identified of being at risk of harm when going out in the community had up to date risk assessments and we saw that, if required, they were supported by staff when they went out during our inspection. No one we spoke with mentioned being restricted; people who were able to went out to the local shops for coffee and to buy magazines. One person told us, "I go to Balham every week."

We looked at 12 care records, all were completed with up to date information for each person using the service. All care records had a comprehensive set of risk assessments covering areas such as moving and handling, dietary needs, positioning and skin integrity, and falls. Staff told us that certain risk assessments were completed for all people, whereas others were based on individual needs. We saw that each person had a nutrition screening tool and referrals were made to healthcare professionals if they were deemed to be at high risk of malnutrition. Staff were familiar with the people they cared for and any risks that they faced.

Staff had received training in managing behaviour that challenged and behaviours that posed a risk of harm to the individual, property or other people. Where people had a history of displaying such behaviours the provider had systems in place to record this behaviour and any perceived triggers to try and reduce them from occurring in the future. These risk assessments and care plans were reviewed every month.

All the people we spoke with and their relatives felt there were enough staff members on duty to meet their needs. People who required assistance when moving told us that two care workers always carried out this task. Relatives told us there was always a member of staff available to speak with. During our inspection we observed alarm call bells being answered quickly and people were not kept waiting if they needed assistance.

Staff told us they were satisfied with the staffing levels at the service. One nurse said, "We help the care workers if they need help." Other staff members said, "Staff levels are fine" and "When we go out on trips we get extra staff."

Some people using the service received one to one care. We saw that where this was the case, the provider arranged for extra staff to provide this support rather than using staff on the existing rota. In addition, if people had to attend healthcare appointments then an additional care worker was brought in to meet this need. We looked at staff rotas and saw evidence to support this.

Good

Is the service effective?

Our findings

People received care from staff who had the knowledge and skills to carry out their roles and responsibilities effectively.

People told us they were very happy with the care they received from staff. One person said, "All the staff are great." One relative told us, "The staff know what they are doing, they provide excellent support."

Staff told us they had sufficient training and support from other staff so that they were able to care for people effectively. They said they held regular handovers and team meetings and had access to good training opportunities. Staff told us that the senior staff and the registered manager were very supportive. One staff member said, "[The registered manager] is always encouraging us to go for more training." There was evidence that training for staff was encouraged by managers; there were posters on display at the home giving dates for a variety of training opportunities for staff to attend.

Through our checks of individual staff training records and discussion with staff, we saw that appropriate training was provided for staff in areas that were relevant to their role. For example, nurses told us they had recently been on venepuncture, catheterisation and tissue viability training. They also said that they had extra training in medication management and for end of life medication as well. Kitchen staff had achieved NVQ Level 3 in food hygiene. A range of training had been provided for staff within the past year, including dementia awareness, care planning, nutrition and infection control. One staff member told us, "We get good training, last week I went on moving and handling training."

We looked at training records, which supported what staff told us. Training certificates and training logs were up to date and training audits were carried out by the registered manager and managers from head office to ensure that staff were up to date with their training requirements.

We found that people were supported to have sufficient amounts to eat and drink. People told us they enjoyed the food. One person said, "It's nice….you always get a choice", another person said, "The food is lovely." One relative told us, "I have no concerns about the quality of food here." We spoke with the chef about menu planning and how they met the needs of people using the service. They told us that all the menus were planned internally but changed seasonally. The head chef met with people using the service once a month to discuss the menu.

During our inspection, we saw staff responding positively to people's requests for drinks or snacks. Drinking water in people's bedrooms was changed regularly and staff ensured it was within the person's reach. During lunch, we saw that there was a choice of meals on offer, and where some people had requested certain food, such as Caribbean meals, these were provided for them. People were given a choice where to eat and staff were observed supporting people to eat and drink whilst trying to encourage independence.

There were completed dietary assessment charts in people's care records and referrals were made to healthcare professionals such as speech and language therapists when necessary. Fluid balance and food intake charts were completed in a timely manner and kept up to date.

Diet information sheets were available for staff to refer to. Some people were on a modified diet, for example if they had difficulty eating and required a softened diet or needed a fortified diet to assist them to gain some weight. Kitchen staff were familiar with people's individual requirements. There was a communication board in the kitchen on which people's individual dietary requirements were recorded.

The provider had achieved a Food Hygiene Rating Score (FHRS) of 5 which was based on how hygienic and well-managed food preparation areas were on the premises. FHRS ratings range between 0 and 5. A rating of 5 is considered the highest rating.

The provider supported people to maintain good health. They had established good links with community healthcare services so that people received ongoing healthcare support. Everyone we spoke with said they were satisfied with the care they received from staff and said they were able to access community healthcare professionals when they needed to. This included GPs and community nursing teams. People were given the choice to remain with their existing GP or register with the visiting GP when they first arrived at the service.

Each person had a named keyworker and a nurse who co-ordinated their care, including making referrals to

Good

Is the service effective?

healthcare professionals outside of the organisation if the need arose. One person said, "[My named nurse] is quite exceptional." Each person had a food and fluid chart, and other weekly weight monitoring sheets. This enabled staff to make a quick referral if they noticed a significant change in people's health. People who were at risk of choking and prone to weight loss were referred to the local community nursing team and their proposed guidelines were followed by staff. One staff member said, "A nurse from the hospice comes in regularly and supports us."

People's care records and incident reports showed that community healthcare professionals were involved in their care where needed. The care records contained referral and outpatient notes, consultant letters, and instructions from GPs and other healthcare professionals. Visits from healthcare professionals such as chiropodists, opticians, dentists, tissue viability and diabetic liaison specialists were recorded. We contacted some healthcare professionals involved with the service for feedback prior to our visit; one told us, "Staff went the extra mile to support him."

We saw examples where people's health and wellbeing had improved during their stay at Heritage Care Centre, these included some people becoming more independent and managing their weight. We saw some examples where the provider had considered extra steps they could take to try and support people and staff more effectively. For example, Heritage Care Centre was a pilot for the local authority's Behavioural Reaction Service where a new in-depth approach to providing care for people displaying challenging behaviours was being tested.

Separate, individual care records were made for people who had developed serious medical conditions. This meant the person's care could be managed more effectively and coordinated so that all the related documentation was kept together in one folder. We looked at one example of this folder which had been arranged chronologically and all the medical records, from the initial diagnosis, to assessments, care plans, body charts, referrals to healthcare professionals, post-surgical notes, wound care and records of Multi-Disciplinary Team (MDT) visits were kept in order. This made it easy for staff to access relevant documentation and allowed them to track the progress of the management of people's health conditions more effectively.

Good

Is the service caring?

Our findings

People using the service told us they enjoyed the company of staff and staff treated them well. They described the staff as being caring and respectful. We observed staff speaking to people with kindness and saw many examples of staff displaying a caring attitude towards people. For example, we saw a staff member reassuring one person who was on their own in the lounge. They sat down with them, talked with them for a few minutes and asked if they needed anything.

Relatives were also satisfied with the staff at Heritage Care Centre. Some of the comments from relatives included, "It's marvellous, you won't find better", "Dedicated, kind, very caring and respectful" and "Very grateful for the care." One relative said that support staff, such as cleaners, were always welcoming and caring.

We observed staff socialising with people using the service and encouraging them to participate in activities. Staff knew people well and could tell us about their medical history but also their past family and life history. This demonstrated that staff made an effort to develop positive relationships with people. One staff member told us, "I like spending time with the residents."

People's needs in respect of their religious and cultural beliefs were met. People told us their religious needs had been catered for. Staff had arranged for communion to be given to one person every week, another had requested to see a priest, this had also been arranged. People were provided with culturally appropriate food.

People told us that their views and wants were taken into consideration whenever possible. They were given the choice of leaving their bedroom door open or closed. We observed staff offering people choices during lunch and asking them if they wanted to take part in the scheduled activities for the day. Staff respected the choices that people made. One person told us, "Activities are okay, sometimes I feel like taking part and other times I don't." Another person said, "Nobody forces you to take part."

We found information in the notes and care plan documentation to evidence that people using the service were actively supported to express their views and wishes. People told us they were able to offer their opinions and staff respected their views. All the care plans were updated monthly or earlier if required. Where relatives had been involved this was also documented. People and their relatives were fully involved when requested to complete 'Do Not Attempt Cardiac Pulmonary Resuscitation' forms.

There was evidence that promoting dignity was an important aspect of the service. Some of the staff at the home were dignity champions. Their role included promoting people's dignity and ensuring they were respected. There was a "dignity board" on display at the home highlighting key information for staff on how they could maintain people's dignity. There was a dignity theme each week at the home, on the day of our inspection the theme was 'Dignity in Care in Communication'. Staff were aware of the importance of respecting people's dignity and what it meant in relation to caring for people. One staff member told us, "Dignity is important for the residents, this is their home."

We observed that dignity and privacy were maintained by staff when meeting people's personal care needs. If people were being moved in the lounge, a privacy screen was used by staff. Discussions with people using the service were discreet, and were conducted in a quiet tone if they took place in a communal area.

The provider dealt with end of life care in a respectful way. The service had achieved the Gold Standard Framework (GSF) for end of life care. GSF is a systematic, evidence based approach to optimising care for all patients approaching the end of life. The provider had established links with a local hospice to provide end of life care.

One staff member who was a palliative care champion and a GSF co-ordinator told us, "I try and ensure staff have a good understanding and training in caring for people on end of life care." Staff were knowledgeable about the specialist care that was required to support people and their relatives. The provider had implemented a discreet colour scheme where staff could identify people who were receiving end of life nursing care. Support was available to families during this period. There were regular assessments and reviews by nursing and medical staff and individual care plans outlining people's end of life preferences. There was a dedicated area in the home for people using the service to pay respects and remember those that had passed away.

Good

Is the service responsive?

Our findings

People told us that their wishes were respected by staff. During our inspection, we saw examples of this in practice. People were having breakfast at different times in the morning to suit their preferences. People who had changed their mind about what they wanted for lunch were also accommodated. On the day of the inspection the kitchen staff told us they respected the cultural preferences of people using the service. We saw that separate meals had been prepared to meet people's cultural preferences.

Personalised care was delivered in a timely fashion and was responsive to people's needs. Each agreed plan had evidence that it was developed in discussion with people using the service, or their relatives. Care plans and risk assessments were reviewed and updated regularly. Any changes requested by healthcare professionals were acted upon in a timely manner. Feedback from professionals was sought by staff if required. Everyone we spoke with said that the care they received was tailored to their individual needs.

Staff told us they acted as keyworkers for people. They were familiar with these people's needs and medical conditions, and also their life history and what they liked and did not like. Personal Information Passports were in place to consolidate this knowledge. Profiles were completed for people using the service, giving an indication of what they liked to do.

People had access to a wide range of activities both within the home and in the community. These included gardening, music movement and day trips to London Zoo. An activity planner for the year was on display at the home. Other activities that had been held involved people's relatives and included a garden party, summer fete and art exhibition. The activities co-ordinator told us, "We manage the activities well. We have a mixture of group and individual activities." They also told us, "I get good support from the care workers."

There was a sensory room available at the home, however we did not see it used during our inspection. There was also a visiting hairdresser who attended weekly and a small shop where people could purchase household items. People told us they found this helpful.

People knew how to make a complaint if they needed to. People told us staff "listen to me" and "if I wanted, I would complain to the manager, but I am happy". One relative told us, "They always keep me informed, if [my family member] doesn't eat or has had a bad night." One relative told us about a complaint they had made in the past and said it was dealt with immediately.

We looked at the recorded complaints since our last inspection in January. These were arranged according to their category, for example if they were related to care, facilities or staff. This allowed the provider to assign the complaint to the appropriate department to investigate. This also enabled them to pick up any recurring themes, so that any common causes of complaints could be resolved. We saw that complaints had been responded to appropriately. Staff knew how to deal with complaints and were clear about the procedures in place.

People and their relatives were encouraged to provide feedback. This was done through a number of ways including, monthly dignity meetings for people using the service. These were chaired by the dignity champion and the activities coordinator. The minutes from these meetings showed that people were satisfied. Relatives meetings were also held. We saw positive feedback from relatives including, "Kept well informed", "Find it easy to talk to staff" and "Pleased with the kind and professional care."

Outstanding ☆

Is the service well-led?

Our findings

Staff completed an induction which introduced them to the values and aims of the service. There was a positive culture at the home where people and their relatives felt respected. The staff were proud of the care they gave. They spoke enthusiastically about people using the service and how they made sure their needs were met. People using the service were keen to tell us how good the care was and how kind and considerate the staff were. Relatives said they "could not fault the care" that was given and told us how caring the staff were.

Staff confirmed they understood the whistleblowing policy and told us they "would not hesitate to report any concerns." They were confident that the manager would act on any concerns they reported.

We found there were clear roles and responsibilities for staff at the home, and all the staff felt valued, including the support staff such as the domestic team. Staff were given responsibility to lead on areas of work, such as unit managers, dignity champions, or GSF champions which made them feel empowered to carry out their jobs. One staff member told us, "It's well organised." Staff also told us that the registered manager "is approachable" and "a really good manager". All the staff we spoke with told us they felt supported by the senior team and enjoyed working at the home. The nurses told us that if they had a problem or a query the manager would offer them help and support. Care workers said they felt supported by the nursing staff and they could approach them for advice. One staff member told us, "They [the managers] helped me a lot."

There was a registered manager in post at the time of our inspection. They had been in post since 2012 and had been employed by the service previous to that. During the inspection we spoke with both the registered manager and the regional manager. They were familiar with the people using the service and staff which indicated that they were actively involved in the running of the home. The provider met legal obligations, including the conditions of registration with CQC, and notified the appropriate authorities of any significant events that occurred at the home.

Regular meetings were held at the home. These included a nurse's handover meeting and a walk around every morning and evening. Other meetings including those for heads of departments, nurses and general staff were held. Each unit had daily handovers. We saw evidence that the GSF coordinator and other healthcare professionals attended meetings which allowed them to share best practice and support staff. Staff clinical supervision was held every two months and staff appraisals twice a year.

The provider monitored the quality of the service provided by carrying out a number of audits on an alternate monthly schedule. The home achieved ISOQAR registration for its quality system in November 2013. ISOQAR is an accredited certification body which audits against a variety of quality, environmental, and other management standards. The manager used an accredited audit tool to audit the home against a variety of quality, environmental, and other management standards. The manager had recently audited against these standards in July 2014.

Some of the audits we saw included areas such as environmental, care documents, health and safety, infection control, dignity, kitchen and nutrition. There were four dignity and two infection control audits conducted each year. The home had implemented a traffic light system for the audits. Any issues that were picked up from these audits were given a green, amber or red rating depending on their impact on people. A red rating signified a major impact that needed resolving as a priority. If any issues were picked up, then an action plan was completed which recorded how the issue was going to be dealt with and resolved. Incidents and accidents at the home were also recorded and monitored to pick up any trends so that they could be minimised in the future. There was evidence that the provider had plans in place to resolve any shortfalls found.

The management team strove for excellence through consultation, research and reflective practice. The manager was able to demonstrate how the home sustained its outstanding practice and improvements over time. The home achieved the GSF in end of life care in November 2011. The accreditation process for achieving the gold standard involves continuous assessment against 20 standards of best practice across a two year period and an official inspection visit at the end. This demonstrated that the provider was consistently following best practice in end of life care over a sustained period. Nurses were trained in end of life care and medication and were dignity champions. Some of the staff had completed a 'train the trainers' course in Dementia Care.

Outstanding ☆

Is the service well-led?

We found that staff worked in partnership with other organisations to make sure they were following current practice and providing a high quality service. The provider consulted with and accessed organisations that supported good practice in care for older people. These included Action on Elder Abuse (AEA) which is a specialist organisation focusing on the issue of elder abuse. The Social Care Institute for Excellence (SCIE) which is a leading improvement support agency set up to improve the lives of people who use care services by sharing knowledge about what works and what's new. The provider had also joined the Dignity in Care Network which is a a nationwide network of over 40,000 individuals and organisations who work to put dignity and respect at the heart of UK care services to enable a positive experience of care. Heritage Care Centre followed guidance as recommended by The National Institute for Health and Care Excellence (NICE) which provides national guidance and advice to improve health and social care.