Heathfield House Nursing Homes Limited

Heathfield House Nursing Home

Inspection report

Heathfield
Bletchington
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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

Overall summary

This inspection took place on 11 May 2015. It was an unannounced inspection. At the last inspection on 26 August 2014 we asked the provider to take action to make improvements relating to people's medicine. The provider sent us an action plan and actions have been completed and improvements made.

Heathfield House is a care home in Bletchington near Oxford that is registered to provide nursing care for up to 48 older people some of whom have dementia. On the day of our visit 37 people were living at the home.

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

Summary of findings

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.

People told us staff knew how to support them. Comments included; "They know how I need to be moved" and "They know me well and just what I require and that's what I get". Staff had the training and support to meet people's needs and support them safely.

People told us they enjoyed living at the home. Comments included; "Everybody is really nice. It's like being on holiday. Everybody is so helpful" and "Staff are really good". People also told us they valued the support they received from staff. They told us staff spent time with them and "nothing was too much trouble".

Staff understood the needs of people and provided care with kindness and compassion. People spoke positively about the home and the care they received. Staff took time to talk with people or provide activities such as and arts and crafts, games and religious services.

People were safe. Staff had received regular training to make sure they stayed up to date with recognising and reporting safety concerns. Records confirmed the service notified the appropriate authorities where concerns relating to abuse were identified.

People received their medicines as prescribed. Staff carried out appropriate checks before administering medicines. Records were accurately maintained and all medicines were stored safely and securely.

Where risks to people had been identified risk assessments were in place and action had been taken to reduce the risks. Staff were aware of people's needs and followed guidance to keep them safe.

The service ensured staff had the necessary skills to support people through, training, and regular supervision. Staff understood their roles and responsibilities and received the support they needed.

The registered manager was aware of their responsibilities under the Mental Capacity Act 2005 (MCA) which governs decision-making on behalf of adults who may not be able to make particular decisions themselves. People's capacity to make decisions was regularly assessed.

People told us they were confident they would be listened to and action would be taken. The service had systems to assess the quality of the service provided in the home. Learning was identified and action taken to make improvements. These systems ensured people were protected against the risks of unsafe or inappropriate care.

All staff spoke positively about the support they received from the registered manager. Staff told us the registered manager was approachable and there was a good level of communication within the home. People knew the registered manager and spoke to them openly and with confidence.

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. Staff knew how to identify and raise concerns.

There were sufficient staff on duty to meet people's needs.

People received their medicines as prescribed. Staff carried out appropriate checks before administering medicines.

Is the service effective?

Good

The service was effective. Staff had the training, skills and support to care for people. Staff spoke positively of the support they received.

People had sufficient amounts to eat and drink. People received support with eating and drinking where needed.

The service worked with health professionals to ensure people's physical and mental health needs were maintained.

Is the service caring?

Good

The service was caring. Staff were kind and respectful and treated people and their relatives with dignity and respect.

People's preferences regarding their daily care and support were respected.

Staff gave people the time to express their wishes and respected the decisions they made.

Is the service responsive?

Good

The service was responsive. Complaints were dealt with in line with the provider's policy. Everyone we spoke with felt confident action would be taken and they would be listened to.

People and their relative's views were sought frequently. Meetings were conducted with people to discuss changes in the home and to seek their feedback.

There was a range of activities for people to engage in. Community links were maintained with local groups who regularly visited the home.

Is the service well-led?

Good

The service was well led. The registered manager conducted regular audits to monitor the quality of service. Learning from these audits was used to make improvements.

There was a whistle blowing policy in place that was available to staff around the home. Staff knew how to raise concerns.

The home had a culture of openness and honesty where people came first.

Heathfield House Nursing Home

Detailed findings

Background to this inspection

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

This inspection took place on the 11 May 2015. It was an unannounced inspection. This inspection was carried out by two inspectors, a pharmacist and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We spoke with ten people, six relatives, six care staff, three nurses, an activities co-ordinator, a kitchen worker, the registered manager and the regional manager. We also spoke with a visiting health professional. We looked at nine people's care records, medicine and administration records. We also looked at a range of records relating to the management of the home. The methods we used to gather information included pathway tracking, which is capturing the experiences of a sample of people by following a person's route through the service and getting their views on it, observation and a Short Observational Framework for Inspection (SOFI). SOFI provides a framework for directly observing and reporting on the quality of care experienced by people who cannot describe this themselves.

Before the inspection we reviewed the information we held about the home, this included; previous inspection reports and notifications we had received. Services tell us about important events relating to the care they provide using a notification. A notification is information about important events which the provider is required to tell us about in law.

Before our inspection we also contacted the commissioners of the service and the care home support service to obtain their views. The care home support service provides specialist advice and guidance to improve the care people receive. We also looked at the 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.

Good

Is the service safe?

Our findings

At our inspection in August 2014 we found appropriate arrangements were not in place for safely managing medicines at the home. This was a breach of regulation 13, management of medicines. We asked the provider to send us an action plan detailing the improvements they would make. At this inspection in May 2015 we found improvements had been made. The home was working with a new pharmacy supplier since our last visit and there were clear systems for the ordering and receiving of medicines. Medicines were received into the home with plenty of time to resolve any discrepancies and records were accurately maintained. All medicines were in stock and balances were correct. Medicines were available when people needed them. We were assured that people were receiving their medicines as prescribed.

Medicines were stored safely and securely. Medicines requiring cold storage were kept within a refrigerator in the treatment room. Temperatures were monitored daily. Liquid medicines including antibiotic syrups had dates of opening on them and eye drops and topical medicines were clearly marked with their expiry dates. All medicines were within their expiry and safe to use. Medicines that required additional controls because of their potential for abuse (Controlled drugs) were handled appropriately and stored securely.

Medicines were administered by nurses and there was a clear record of the staff allowed to perform this task. No one was self-administering their own medicines but there was provision within the home if people expressed a wish to do so. Protocols for the administration of 'as required' medicines were available and the home had a policy for administration of homely remedies. This is where administration of some medicines that are purchased at a pharmacy is allowed to treat people for minor ailments with the consent of their GP. It was clear when people had received a homely remedy and accurate records were maintained.

Five people were receiving their medicines covertly. For example, hidden in food or drink. There was a record of the decision making process and who was involved, including the GP, family member or advocate. The home manger confirmed that the GP formally reviewed the appropriateness of covertly administered medication every six months.

There was a medication management policy and we saw a record of medicines incidents was being maintained.

People told us they felt safe. Comments included; "I need a lot of help physically, and yes, I always feel safe. I have my call bell to hand and the staff come quickly when I need them" and "They check me every hour at night". We saw call bells were available and placed within reach for people in their bedrooms. A relative said "My wife is very, very safe".

Staff we spoke with could clearly explain how they would recognise and report abuse. Staff told us, and training records confirmed that staff received regular training to make sure they were able to identify abuse. They told us they would report concerns immediately to their manager or senior person on duty. They were also aware they could report externally if needed. One member of staff said, "I could contact the CQC (Care Quality Commission) if needed, and the safeguarding team at OCC (Oxfordshire County Council)". Another said "If I saw something I would report it to the person in charge, nurse, manager. To protect myself and the residents".

Risks to people were managed and reviewed. Where people were identified as being at risk, risk assessments were in place and action had been taken to reduce the risks. For example, one person was at risk of falling out of bed. The risk assessment stated bed rails should be used to 'reduce the risk and keep the person safe'. The assessment also took account of the risks associated with the use of bed rails such as the bed rail creating an entrapment hazard. The risk assessment recorded the rails were appropriately fitted and checked monthly. We went to this person's room and saw the bed rails fitted, with their consent, in line with the assessment guidance.

Another person was at risk of developing pressure ulcers. They had been assessed by the GP and visited by the Care Home Support Service. The care home support service provides specialist advice and guidance to improve the care people receive. Measures in place to reduce the risk to this person, included pressure relieving equipment, checking the person's skin condition and repositioning the person regularly. Staff followed the guidance and the person did not have a pressure ulcer. Other risks assessed included dependency, mobility, falls, and nutrition. Staff had details of actions to take for each person in emergency situations. For example, PEEPS (personal emergency evacuation plans) were recorded in their care records.

Good

Is the service safe?

There were sufficient staff on duty to meet people's needs. The registered manager told us staffing levels were set by the "dependency needs of our residents." During the day we observed staff were not rushed in their duties and had time to chat with people and engage with them in activities. Call bells were answered promptly.

People told us there were sufficient staff. One person said "I don't have to wait long for staff to come and help me". Staff told us there were "Enough staff on every shift" and "Staffing is adequate at the moment but we can always do with an extra pair of hands".

Records relating to the recruitment of new staff showed relevant checks had been completed before staff worked unsupervised at the home. These included employment references and Disclosure and Barring Service checks. These checks identify if prospective staff have a criminal record or were barred from working with children or vulnerable people.

Good

Is the service effective?

Our findings

People told us staff knew their needs and supported them appropriately. Comments included; “They know how I need to be moved” and “They know me well and just what I require and that’s what I get”. One relative said “My wife is really well cared for, they know her and her ways and can achieve results. The first place she was in was not good and she stopped walking. Soon after coming here she was walking again. I cannot speak highly enough of this home”.

Staff had the skills and knowledge to carry out their roles and responsibilities. Staff told us they received an induction and completed training when they started working at the service. They told us they had regular supervisions which took place every” two or three months, and appraisals each year”. Induction training included fire, moving and handling, infection control, use of bed side rails and the Mental Capacity Act (MCA). Some staff had received training in dementia care. Training updates were available to staff on the ‘Log on to Care’ computer system. (An online training system for staff).

Staff told us, and records confirmed they had effective on-going support and development opportunities. . For example, one member of staff had asked for additional training in end of life care and this had been provided. Supervisions were recorded and actions for staff carried over to the next supervision to monitor their progress. For example, one member of staff had stated on their supervision they ‘lacked confidence’. The action was for them to work with their mentor to gain more knowledge and confidence. We saw the next supervision had recorded this action was completed and the member of staff felt more confident. Another member of staff told us how their training had helped them. They said “It made me look at things differently, gave me more knowledge”.

We discussed the Mental Capacity Act (MCA) 2005 with the registered manager. The MCA protects the rights of people who may not be able to make particular decisions themselves. The registered manager was knowledgeable about how to ensure the rights of people who lacked capacity were protected. Care records showed the principles of the Mental Capacity Act 2005 code of practice had been followed when assessing an individual’s ability to make a specific decision. For example, one person required bed rails to keep them safe in bed. The person was assessed and they did not have capacity to make that decision. Records confirmed the person’s best interests were considered by both staff and the person's relatives.

All the staff had received training in the MCA but when we spoke with them their understanding was limited and many could not explain the principles of the act. However, staff adhered to the principles in their day to day work. For example, staff talked about making sure that people were given choices and their privacy respected. The records supported this. For example, care plans noted how the person was “Able to choose her jewellery” and “Likes to have her make up on”. One member of staff described how they provided care for one person. They told us “They refuse care sometimes, we just try and persuade them, and may have to come back later”. The registered manager told us they were planning to review MCA training to ensure all staff had the knowledge they needed.

At the time of our visit three people were subject to a Deprivation of Liberty Safeguards (DoLS) authorisation. These safeguards protect the rights of people by ensuring that if there are any restrictions to their freedom and liberty these have been authorised by the supervisory body as being required to protect the person from harm in the least restrictive way. For example, one person lacked the capacity to decide where to live. Healthcare professionals, the GP and family were involved in the process and the person’s best interests considered. The person was not aware of the risks or dangers to living alone and the supervisory body had authorised the application to ensure the person was protected from harm.

People were supported to maintain good health. Various professionals were involved in assessing, planning, intervening and evaluating people’s care and treatment. These included the GP, Care Home Support Service, Speech and Language Therapist (SALT) and physiotherapist. We spoke with a visiting health professional and asked about the service. They said “I think it has got a lot better. I attend regularly, they follow advice and communication is very good. I have no problems with this service.” Visits by healthcare professionals, assessments and referrals were all recorded in people’s care plans.

One person needed support with their mobility. Their needs had been assessed and other healthcare professionals had visited this person including the district

Good

Is the service effective?

nurse, dietician and chiropodist. Guidance for staff on how to support this person was detailed and stated the person required two staff to support them for all transfers. The person had a personal sling in their room for use with a hoist. This person told us the service "Regularly reviewed the care plan". They were also at risk of losing weight and the person's nutrition plan had been reviewed and changed. Their condition was being monitored and they were not losing weight.

People had sufficient to eat and drink. We observed the lunchtime meal and saw it was a relaxed and enjoyable experience. The meals were served hot from the kitchen and looked wholesome and appetising. Where people needed assistance with eating and drinking they were supported appropriately. Staff were patient and caring, offering choices and providing support in a discreet and personal fashion. Menus were provided weekly and staff helped people choose what to eat. Where people required special diets, for example, pureed or fortified meals, these were provided. We spoke with a member of kitchen staff who told us people's diet sheets were "checked daily with the nurses to keep them up to date. We hold this information in the kitchen". People's comments included; "The food is good", "I don't see anything to grumble about. The staff are so nice and friendly. They ask you what you want to eat. Nothing is a problem" and "I have never been disappointed yet".

Some people were having their food and fluid intake monitored. Charts were all kept in one file in the dining room. There was general guidance displayed on the wall in the nursing office about how to calculate daily fluid intake targets for people. However, daily targets were not recorded on people's individual fluid charts, therefore staff were not provided with the information they needed to confirm the people had the fluids they needed. However, we checked people's weight charts and saw this had not impacted upon people. We spoke with the registered manager about this who told us they would address this "as a priority" and ensure the records were updated.

Malnutrition Universal Screening Tool (MUST) assessments were completed, and it was evident from the records we saw that actions had been taken in response to changes in people's weights and body mass index (BMI) recordings. For example, one person had complex care needs, a dietician had been involved and their support had been amended. We saw that the Speech and Language Therapist (SALT) team had been consulted for another person who required a modified diet. Staff were able explain the types of diet required for people. All the people's records we saw confirmed they were maintaining or gaining weight.

Good

Is the service caring?

Our findings

People told us they enjoyed living at the home. Comments included; “Everybody is really nice. It’s like being on holiday. Everybody is so helpful”, “Staff are really good, and I can say if there are any problems”, “They (the staff) are so kind” and “Everything is good here. I’m just here for a few weeks, and I spend the day sometimes in my room and sometimes I go downstairs for meals. I choose what I want to do”. Relatives comments included; “My wife is really well cared for. I couldn’t look after her myself and no one could do any better. Staff are absolutely brilliant”, “The carers are excellent. They give 110%” and “I think the care is superb. They are always good about birthdays. They bake a cake, all sing, they really spoil them”.

Staff were knowledgeable about the care people required and the things that were important to them in their lives. We saw they conversed with people about their careers, family and where they had lived. Care plans listed people’s preferences and staff were able to tell us about them. For example, one staff member told us the person they were supporting “Liked their tea a certain way, milky but without sugar”.

Throughout our visit we saw people were treated in a caring and kind way. The staff were friendly, polite and respectful when providing support to people. Staff took time to speak with people as they supported them. For example, one person, who was living with dementia, liked to spend time walking around the garden. We were told they would do this for hours at a time. We observed this person walking and saw every ten to 15 minutes a member of staff would go into the garden to check they were okay and offer support. On one occasion they took a warm coat out to the person because the weather had changed. They would briefly chat with the person before leaving them to walk. We observed staff communicating with people in a patient and caring way, offering choices and involving people in the decisions about their care. For example, at lunchtime we saw people’s preferences of what to eat and drink were respected.

People’s dignity and privacy were respected. We saw staff call out to people if their room doors were open before they walked in, or knocked on doors that were closed. Where they were providing personal care people’s doors were closed. One member of staff said “It is so important to be respectful. Everyone has their own way, and we need to know how they like to be treated”. Another member of staff told us the document ‘All about me’, held in people’s care plans, helped them when they were new in post. They said it really helped them “Get to know the person they were caring for”. A relative said “All staff here are very polite and helpful”.

We observed many positive interactions. For example, staff would sit and read with people, engage in an activity or simply sit and talk with them. We observed one member of staff greeting a new resident. They bent down to the person’s level and spoke quietly and calmly, giving them time to respond. Staff treated people with dignity and compassion. We saw how staff spoke to people with respect using the person’s preferred name. When staff spoke about people to us or amongst themselves they were respectful.

Staff gave people the time to express their wishes and respected the decisions they made. For example, we observed a member of staff offering a person a choice of drinks. They spoke calmly and gave them time to decide. The person chose orange juice and this was provided. Staff then asked where they would like to sit to have their drink and the person’s preference was respected.

Good

Is the service responsive?

Our findings

People's needs were assessed prior to admission to the service to make sure their needs could be met. Care records contained an 'About me' document with details of people's personal histories, likes, dislikes and preferences and included people's preferred names, interests, hobbies and religious needs. This showed us people had been involved in their assessment. Care plans were detailed, personalised, and were reviewed on a monthly basis. The level of involvement people had with their plans, their views and the contribution they could make was recorded. One person told us "I don't mind female or male carers, but I know if I said I only wanted female staff it wouldn't be a problem". Another had stated "I do not like my feet being tickled".

The service responded to people's needs. For example, one person's goal was listed as 'Remain comfortable and pain free'. The plan noted the person had difficulty communicating verbally. Guidance for staff on how best to support this person stated 'Observe for any physical signs of pain, including agitation, facial expressions or withdrawal'. Picture form pain charts were included in the plan to assist the person to communicate their level of pain. Staff were aware of this person's needs and told us they followed the guidance.

We saw the morning activity musical session. Several people were taking part, and singing or playing a musical instrument. One person who was unable to communicate verbally could be seen wriggling his toes to the rhythm of the music. The weekly activity programme was displayed in the home. This included arts and crafts, bingo, flower arranging and games. The activity coordinator told us they arranged for some activities to take place during the weekends. They also told us how they encouraged community involvement in the home, from churches and a local school.

People were protected from the risk of social isolation. The coordinator told us they visited people in their rooms on a weekly basis, in addition to 'pop in' visits when they delivered the morning newspapers. One person who stayed in their room told us, "I had a lovely manicure the other day". External entertainers provided entertainment on an approximate fortnightly basis.

The home had a large, well maintained garden area for people to enjoy. Access to the garden was unrestricted and we saw people using the garden which was accessible for people who used wheelchairs. Brick built raised borders were available for people who used wheelchairs so they could participate in gardening activities. A large, level patio formed the centre of the garden and we were told this was used for BBQs. Staff regularly visited the garden to make sure people were safe and to provide support if it was needed. Chickens and rabbits were kept in the garden and we were told the rabbits were popular with people, who sometimes took them into the home to pet. The home also had a sensory bathroom with light sensory stimulation equipment, a bath lift and piped calming music for people to enjoy.

People knew how to complain and were confident action would be taken. Comments included; "I know how to make a complaint but I haven't needed to" and "Yes, I'm sure something would be done if I did". The service had a complaints policy in place which was displayed on a notice board in reception. The complaints policy also formed part of the 'service user guide' and contract given to all people and their relative's when they moved into the home. There had been one complaint since our last inspection. This was investigated and resolved to the person's satisfaction and an apology was given. Staff were aware of the policy and knew how to assist people to complain if they so wished. The registered manager told us they regularly reviewed comments and complaints to "Look for patterns".

'Residents and relative's' meetings were regularly held. People and their relatives could raise issues with the staff and registered manager. For example, one person had stated "The food is too posh" and went on to say they preferred a plainer menu. The service reviewed the menu. The next meeting recorded how the food was now more 'Homely'. Another person had made suggestions for the dining room including a wall painting. One other person said they could paint a picture and they were given the opportunity to do so. Their picture was on the dining room wall and we were told they were going to paint another in the music room.

The service sought people's opinions via regular surveys. Opinions relating to care, dignity and respect were included in the surveys and people had the opportunity to raise issues within the document provided. Issues and comments were analysed and the results fed back to

Good

Is the service responsive?

people and staff. For example, the issue of doors banging was raised. This was looked into and it was recorded the "door closers had been adjusted" to reduce the noise. Another issue raised was a request for a hairdresser to visit the home. We saw a hairdresser now visited the home for one day every week. The regional manager had also offered to meet with people or their relative's to discuss any aspect of the service.

Good

Is the service well-led?

Our findings

Regular audits were conducted to monitor the quality of service and learning from these audits was fed back to staff to make improvements. For example, one audit identified an annual review of care was due. The review was conducted and we saw the results were shared with staff at supervision and staff meetings. Audits areas included care plans, medicines, accidents and incidents, nutrition and weights and key worker reports.

Staff knew their roles and responsibilities and understood what was expected of them. Job descriptions held in staff records detailed their roles and responsibilities and staff told us they could discuss these at supervision meetings with their line manager.

All the people we spoke with knew who the registered manager was and told us they were approachable. The registered manager knew people by their name and took time to talk with them. People and staff spoke positively about the registered manager, senior staff and the support they received. One member of staff said, “We all work well together”. Another said “The manager is very efficient. She is fair and firm, but she is always approachable. The regional manager is too”. Staff told us they felt well supported and would not hesitate to ask if they needed support, direction or guidance from the registered manager. One person said “I always have a chat with the manager when I see them”. Members of the senior management and directors regularly visited the home and attended meetings with both people and staff.

The registered manager discussed concerns with staff . They used supervision meetings and the disciplinary procedure to resolve issues, share learning and provide advice and guidance for staff to prevent future occurrences. This showed the service did not display a culture of blame. The registered manager said they “Look for answers, not blame”.

The service had good links with the local community. For example, the local primary school visited the home and their art work was on display in communal areas around the home. The school also celebrated annual events with the home such as Easter, and November 5th. The local church visited and held regular services and ministers visited individuals if they requested. The homes open day was planned and included visits from the local school, relatives and friends of the home and was themed as a ‘Farm day’.

There was a whistle blowing policy in place that was available to staff around the home. The policy contained the contact details of relevant authorities for staff to call if they had concerns. This included the Care Quality Commission (CQC). Staff were aware of the policy. One nurse said “It’s about contacting services if you are concerned about how residents are being treated”.

The service worked in partnership with visiting agencies, particularly the NHS and local authority. For example, people’s allergies were recorded, however in one case there was conflicting information with regards to allergies. The person was recorded to be allergic to a particular medicine for nausea but their MAR chart did not indicate this. The home had already raised this with the pharmacist and the pharmacist was due to visit the week of our inspection to check that all allergy information was accurately reflected on the MAR charts. This partnership working reduced the risk to people receiving the wrong medicine. The service had strong links with local community health teams and with the service commissioners, who spoke positively about the service. Comments included; “They have definitely improved over the last year”, “Communication is good, I have no current concerns” and “A good open service that has come a long way”.

Services that provide health and social care to people are required to inform the Care Quality Commission, (the CQC), of important events that happen in the service. The registered manager of the home had informed the CQC of reportable events.