Randomlight Limited

Heightside House Nursing Home

Inspection report

Newchurch Road
Rawtenstall
Rossendale
Lancashire
BB4 9HG

Tel: 01706830570
Website: www.heightsidehouse.co.uk

Date of inspection visit:
19 February 2018
20 February 2018
21 February 2018

Date of publication:
23 April 2018

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Good**
Is the service caring?	**Good**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

We carried out an unannounced inspection of Heightside House Nursing Home on 19, 20 and 21 February 2018.

Heightside House Nursing Home is a care home which is registered to provide nursing care and accommodation for up to 78 adults with mental ill health. People in care homes receive accommodation and nursing care as a single package under one contractual agreement. CQC regulates both the premises and the care provided and both were looked at during this inspection.

Accommodation is provided in four separate 'units.' The House, The Mews, Close Care and The Gate House. There is also a separate rehabilitation/activities centre. The House is an adapted premises and incorporates the High Dependency Unit and has both single and double bedrooms over four floors. Some bedrooms have en-suite facilities. There are two lounges, one lounge/dining room, a separate dining room and a room for people who smoke. A passenger lift provides access to all floors. The Mews is purpose built and consists of one six bedded unit, shared bungalows and flats. Close Care is a purpose built premises and includes a seven bedded unit and a bungalow accommodating four people. The Gate House is an adapted building and can accommodate up to three people. All the bedrooms are single occupancy and there are communal lounges/dining areas.

The service was managed by a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At our last inspection on the 22 and 23 February 2017 the overall rating of the service was 'Requires Improvement'. We found progress was needed with medicines management, checking systems and provider oversight of the service. We therefore made recommendations on these matters.

During this inspection we found the provider was in breach of two regulations of the Health and Social Care Act (Regulated Activities) Regulations 2014. The breaches related to a lack of robust processes for mitigating and managing risks to individuals, also quality monitoring and oversight. You can see what action we told the provider to take at the back of the full version of this report. We also found some further progress was needed with acting upon people's views, ideas and suggestions and have therefore made a recommendation on this matter. This was the third consecutive time this service has been rated Requires Improvement.

We found there were good management and leadership arrangements in place to support the day to day running of the service. However it was not clear the provider had proper oversight of the service. We noted there was a lack of information to show how they assured themselves about the quality and safety at the service.

Systems were in place to maintain a safe environment for people who used the service and others. Processes were in place to prevent and control the spread of infection. We found some matters were in need of attention and the registered manager commenced action to make improvements.

There were safe processes in place to support people with their medicines, but some improvements were needed.

Recruitment practices were in place to make sure appropriate checks were carried out before staff started working at the service. There were enough staff available to provide care and support and staffing arrangements were kept under review.

Staff were aware of the signs and indicators of abuse and they knew what to if they had any concerns. Staff had received training on safeguarding and protection matters. They had also received training on positively responding to people's behaviours. The service monitored incidents and accidents and to ensure there was a proactive 'lessons learned' approach.

Arrangements were in place to gather information on people's backgrounds, their needs, abilities and preferences before they used the service.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible. Policies and processes at the service supported this practice

We found people were supported with their healthcare needs and medical appointments. Changes in people's health and well-being were monitored and responded to. Policies had been introduced to provide guidance for staff on supporting people who refused support with their healthcare needs.

People had mixed views about the quality and variety of meals provided at Heightside House. However we found action was being taken to make improvements.

People made positive comments about the care and support they received from staff. We observed positive and respectful interactions between people who used the service and staff.

Each person had a care plan, describing their individual needs and choices. This provided guidance for staff on how to provide support. People had been involved with planning and reviewing their care. However we found improvements were needed with some aspects of care planning and reviews.

People had been actively involved with the up-grading of the premises, including choosing furniture, colour schemes and soft furnishings.

People were supported with their hobbies and interests, including activities in the local community and keeping in touch with their relatives and friends. There were opportunities for skill development and promoting independence.

There were processes in place for dealing with complaints. There was a formal procedure to manage, investigate and respond to people's complaints and concerns.

There were systems in place to consult with people who used the service, to assess and monitor the quality of their experiences.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

We found some risks to people's individual wellbeing and safety had not been properly assessed and managed. There were safe processes in place to support people with their medicines. However, some improvements were needed.

There were enough staff available to provide people with safe care and support. Staff knew how to report any concerns regarding possible abuse and were aware of the safeguarding procedures.

Processes were in place to maintain a safe environment for people who used the service. However we found some safety matters required attention.

Is the service effective?

Good

The service was effective.

Processes were in place to find out about people's individual needs, abilities and preferences. People's health and wellbeing was monitored and they had access healthcare services when necessary.

People had mixed views about the quality and variety of meals provided. However we found action was being taken to make improvements.

People were encouraged and supported to make their own choices and decisions. The service was meeting the requirements of the Mental Capacity Act 2005.

Arrangements were in place to develop and supervise staff in carrying out their roles and responsibilities.

Is the service caring?

Good

The service was caring.

People made some positive comments about the supportive and

caring attitude of staff. We observed positive and respectful interactions between people using the service and staff.

Staff were aware of people's individual needs, backgrounds and personalities, which helped them provide personalised support.

People were supported in a way which aimed to promote their dignity, privacy and independence.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care planning needed some improvement, to promote a more personalised and responsive approach to people's needs and aspirations.

People had opportunities to maintain and develop their skills. They had access community resources, to pursue their chosen interests and lifestyle choices.

There were processes in place to manage and respond to complaints, concerns and any general dissatisfaction with the service. However progress was needed in validating and responding to people's suggestions for improvements.

Is the service well-led?

Inadequate

The service was not well led.

There was a management team providing leadership and direction of the service.

Quality monitoring arrangements had improved, but we found some checking systems could be better. There was also a lack of evidence to confirm the provider had proper oversight of the service.

There were processes in place to monitor and check the quality of people's experience of the service.

Staff were knowledgeable and positive about their work. They indicated the registered manager was supportive and approachable.

Heightside 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 checked 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.

We visited Heightside House Nursing Home on 19, 20, 21 February 2018 to carry out an unannounced comprehensive inspection. The inspection team consisted of two adult social care inspectors, an inspection manager a specialist advisory (speech and language therapist) and 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.

The inspection was prompted in part by an incident which had a serious impact on a person using the service and this indicated potential concerns about the management of risk in the service. While we did not look at the circumstances of the specific incident, which may be subject to criminal investigation, we did look at associated risks. We were also aware of a past incident of choking at the service. This inspection therefore examined the current care and treatment related to maintaining people's hydration and nutritional needs. We know that the incidents have also been brought to the attention of the Police and the Local Authority safeguarding team.

Before the inspection, we reviewed the information we held about the service, including notifications and previous inspection reports. A notification is information about important events which the service is required to send us by law. We contacted the local authority contract monitoring team, the local authority safeguarding team, commissioners of care, a pharmacist and visiting health care professionals. The provider sent us a Provider Information Return (PIR). This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We used all this information to decide which areas to focus on during the inspection.

We used a number of different methods to help us understand the experiences of people who used the service. During the inspection visit, we spent some time with people, observing the care and support being delivered. We talked with nine people who used the service about their experiences of their care and support. We talked with four healthcare support workers, the chef, five nurses, the administrator, the head housekeeper, a cleaner, deputy manager and the registered manager.

We looked at a sample of records, including six care plans and other related care documentation, three staff recruitment records, training records, menus, complaints records, meeting records, policies and procedures, quality assurance records and audits.

Requires Improvement

Is the service safe?

Our findings

We looked at how risks to people's individual safety and well-being were assessed and managed. Individual risks had been identified in people's care records. However we found variations in the quality of this practice. Some of the instructions for managing risks were lacking in detail and clarity. For example, one risk assessment entry indicated the person was at risk of choking as they consumed food quickly, but there was a lack of specific information on how to manage this risk. One care plan record included contradictory information about the person's dietary needs; one written entry described the person as requiring a 'normal diet' yet another entry stated they required a 'soft diet.' We also noted a lack of instructive guidance for example, on strategies for positively responding to risks around a person's behaviours. This could result in people's risk management needs not being known and appropriately shared with staff responsible for delivering care.

There were instances where identified risks had not been reviewed in accordance with the provider's defined procedures. Records showed there were three to four month gaps between some documented care plan reviews. One person's care plan had not been reviewed for three months; despite two choking incidents that had occurred during the previous review period. We also noted risk assessments on 'verbal and physical aggression' and 'risk of leaving the site' were graded as 'low risk' but had not been reviewed since October 2016. In addition we saw some risk assessments had not been dated, which meant processes for reviewing and managing the identified risks may not be effective.

The provider had failed to appropriately assess all risks to the health and safety of people who used the service. We also found the measures in place to mitigate such risks were not always robust. This was a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The risk assessments we reviewed included, skin integrity, nutrition and falls. Strategies had been drawn up to guide staff on how to monitor and respond to identified risks. There was a 'comprehensive risk assessment' around mental wellbeing and behaviours. This incorporated an initial risk screening tool and a more in-depth risk assessment process. The key themes covered included: risk to others, risk of suicide, self-harm, physical violence, sexual violence, vulnerability/exploitation/self-neglect and choking. The processes resulted in risk management plans with actions for staff to follow on minimising the risks to the individual.

Staff spoken with were very knowledgeable about people's individual needs and circumstances. They knew people well and were able to describe in some detail how they managed risks. One healthcare assistant told us, "We can't take the risks out of their lives. But risks are managed. Care plans are in place to minimize risks. It just needs some planning to enable people to do things safely." We observed staff responding effectively to people's behavioural needs in a calm and sensitive manner. We noted specific examples where people identified at risk of choking, were vigilantly and very considerately supported by staff to eat their food. We found some risk assessments provided clear, precise and person centred details for staff on providing people with safe support with food and drink.

Records were kept of any accidents and incidents that had taken place at the service. We noted the records

were detailed and provided clear information. Processes were in place to monitor any accidents and incidents so the information could be analysed for any patterns or trends. Referrals were made to relevant health and social care agencies as appropriate.

We reviewed how the service protected people from abuse, neglect and discrimination. The people we spoke with indicated they felt safe at the service. Their comments included, "I do feel safe here. It felt strange at first, but I'm very happy now," "Yes I feel safe now" and "I am safe, I'm happy here." We did receive some comments from people about how the behaviours and actions of others had impacted upon their experiences at the service. For example, one person said, "I do feel safe here. But sometimes when other users are angry, I get scared" and another person commented, "I haven't always felt safe here, as people have been able to walk into my room."

Prior to the inspection we reviewed the information we held about the service relating to safeguarding incidents and allegations of abuse. We discussed and reviewed some of the concerns with the registered manager. We found action had been taken to liaise with local authority and other agencies in relation to the allegations and incidents. The registered manager indicated the service was working in accordance with the local authority's revised safeguarding protocols. It was apparent the service had taken seriously their responsibilities to monitor any safeguarding incidents and accidents and to ensure there was a proactive 'lessons learned' approach. Systems were in place to record and manage safeguarding matters, including the actions taken to reduce the risks of re-occurrence. A commissioner of services told us they were reassured that registered manager was open and candid about safeguarding and staffing concerns that had been brought to his attention. Following significant incidents at the service, quality review meetings had been held and action taken to make improvements. This had included the obtaining of additional specialised equipment, further staff training, increased monitoring processes and changes in policy and protocols.

Staff spoken with expressed a good understanding of safeguarding and protection matters. They were aware of the various signs and indicators of abuse, including physical abuse, psychological harm and potential discrimination. They were clear about what action they would take if they witnessed or suspected any abusive practice. Staff said they had received training and guidance on safeguarding and protecting adults. This included training on positively responding to behaviours that were challenging and minimal physical interventions. Staff had access to individual personal alarms, should they need to summon emergency support for the protection of themselves and others. However we noted not all staff were carrying the alarms which raised concerns around people's safety and protection. There were three 'safeguarding champions', which are staff with designated responsibilities for safeguarding matters. The service had policies and procedures to support an appropriate approach to safeguarding and protecting people. We noted information was available around the service, from the local authority on adults at risk and keeping people safe. Staff spoken with were also aware of the service's 'whistle blowing' (reporting poor practice) policy and expressed confidence in reporting any concerns.

We looked at the way the provider supported people with the proper and safe use of medicines. One person told us, "Staff have my tablets, they give me them when I need them." We found processes were in place to support people to manage and have involvement with their medicines. We reviewed how this was being safely managed in response to one person's individual needs, preferences and abilities. However another person explained, "Staff look after my medication. I don't want to."

At our last inspection we found there were some shortfalls with medicines management processes which were rectified during our visit. However to help mitigate further risks in a timely way, we recommended the medicine management auditing systems be developed. At this inspection we found improvements had been

made and processes were in place to provide people with safe support. We also noted a more comprehensive medicines audit and checking systems had been introduced to identify shortfalls and make improvements. Prior to the inspection we spoke with a community pharmacist who supplied the service. They had no concerns about the medicines processes in place, which they considered were safe. They told us staff dealing with medicines were "Proactive and knowledgeable" and "Keen to get things right."

We checked the procedures and records for the storage, receipt, administration and disposal of medicines. We checked medicines storage areas which were found to be clean, tidy and secure. There was a monitored dosage system (MDS) for medicines. This is a storage device provided and packed by the pharmacy, which places tablets in separate compartments according to the time of day. We checked the arrangements in place for the management and storage of controlled drugs which are medicines which may be at risk of misuse. We found appropriate secure storage was provided and that the stock levels accurately corresponded to were in agreement with the recorded balance. The provider had introduced a stock of 'homely remedies.' People's GP's had been contacted to agree their compatibility with any prescribed items. This meant people would benefit from access to 'over the counter medicines' in a timely way.

The processes included staff having sight of repeat prescriptions prior to them being sent to the pharmacists. The medicines administration records (MAR) we reviewed for items taken by mouth were appropriately kept, complete and accurate. We found there were specific protocols for the administration of medicines prescribed "as necessary" and "variable dose" medicines. The protocols are important to ensure staff were aware of the individual circumstances this type of medicine needed to be administered or offered. However, safe processes were not in place to demonstrate the application of people's external medicines, such as topical creams. There were no 'body map' diagrams to provide directions to staff on where to apply creams and the MARs were lacking in clarity to confirm they had been appropriately applied.

Staff responsible for administering medicines had received medicines management training and processes to assess their competencies in undertaking this task were ongoing. Staff had access to a range of medicines management policies, procedures and nationally recognised guidance which were available for reference. We reviewed the policies and procedures for medicines management and found they were lacking in detail on providing clear instructions step by step instructions on medicines administration. There was also a lack of guidance on key aspects of safe medicines management. For example, there was no policy to direct an appropriate response to the 'self-administration' of medicines.

We looked at the processes in place to maintain a safe environment for people who used the service, visitors and staff. At our last inspection, we found some improvements were needed with the premises. At this inspection, we noted action had been taken to make improvements had been made. For example, handrails had been provided to the steps leading to the House, additional call point in bathrooms had been provided and a corridor carpet which had presented as unhygienic had been replaced. However, we received comments from people who used the service around their safety at night, as the door locks in use could not assure their safety from the intrusion of others. We checked several bedroom doors and found they were fitted with locks, but not all of them provide suitable safety and security for the occupants. We discussed this matter with the registered manager who assured us action would be taken to make improvements. We also noted several doors across the service frequently banged, which meant people were not free from the intrusion of unnecessary noise.

We looked around the grounds and noted areas of erosion including 'potholes' in the asphalt on outside drives and walkways which presented as a health and safety risk to people using the service, staff and visitors. We were advised that work estimates had been obtained to resurface these areas in 2016, however approval to commence the work had not been granted.

There were contingency procedures to be followed in the event of emergencies, disasters and failures of utility services and equipment. There were various health and safety checks carried out on the premises. However we noted the last health and safety risk assessments had not taken into consideration the grounds. Processes were in place to identify and attend to general maintenance and repairs. There were regular communal room audits, but no structured checks on the suitability and safety of people's bedrooms. However the housekeeper took action to re-introduce such audits during our visit. There were accident and fire safety procedures available. Records and service agreements showed processes were in place to check, maintain and service fittings and equipment, including gas, water quality, fire extinguishers, hoists and the passenger lift. We found fire safety risk assessments were in place. Fire drills and fire equipment tests were being carried out. Contract agreements were in place for the removal of hazardous and clinical waste. We found the services electrical installations safety certificate had expired on 4 January 2018 however, we received clear evidence to confirm this matter was in hand.

We reviewed how people were protected by the prevention and control of infection. People spoken with did not express any concerns about the cleanliness of the service. The areas of the service we looked at were kept clean. Suitable cleaning equipment and laundry facilities were provided. Protective personal equipment, including gloves, aprons and anti-bacterial hand wash was available. We noted guidance on effective hand hygiene was displayed. Records and discussion indicated staff had completed training on infection control and there were associated policies and procedures to provide direction and guidance for staff. There were processes to audit, monitor and respond to infection prevention and control measures at the service. This meant arrangements were in place to check, maintain and promote good hygiene standards.

We checked if the staff recruitment procedures protected people who used the service. All the people we spoke with said they were not involved at any level with staffing or staff selection. We reviewed the recruitment records of three new recruits. The recruitment process included candidates completing a written application form and attending a face to face interview. Character checks including, identification, obtaining written references, checks on employment history and reasons for leaving previous positions had been carried out. There was also a system in place to check that nurses employed in the service were registered with the Nursing and Midwifery Council. An appropriate DBS (Disclosure and Barring Service) check had been completed. The DBS carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults, to help employers make safer recruitment decisions. We found one example where a health screening check had not been carried out prior to the person commencing duty and evidence of their stated qualifications obtained. However action was taken to rectify these matters and prevent any recurrence during the inspection. Arrangements were in place for new employees to undergo a probationary period to monitor their conduct and competence. The service had disciplinary procedures in place to manage unsafe and ineffective staff conduct.

We reviewed how the service managed staffing levels and the deployment of staff to support people to stay safe and meet their needs. People spoken with did not express any concerns about the availability of staff at the service. They told us there was a consistent and regular staff team, but that agency staff were also regularly used. The registered manager said the use of agency staff was monitored and the service aimed to use the same staff, to provide better continuity of care and support. The registered manager indicated staffing reviews were ongoing, in response to people's changing needs and abilities. We noted people's individual care records included a 'dependency assessment' which assisted in identifying safe staffing arrangements at the service. During the inspection we found there were sufficient staff on duty to meet people's needs. We observed support being provided in a timely and consistent way. Staff spoken with considered there were mostly enough staff on duty at the service. However we were told there was occasionally some movement of staff between the units to provide cover, which created a knock-on effect.

There was a 'staffing plan,' which identified the required staff deployment structure for each designated area of the service. The plan specified the numbers and roles of staff to be on duty. This included nurse qualified staff and health care assistants. We looked at the staff rotas, which showed arrangements were in place to maintain consistent staffing levels. There were nurse qualified staff within the management team, who could be available for cover and support as needed. The service had activity coordinators and the support of a psychiatrist and an occupational therapist. There was a housekeeping team, catering team, maintenance staff, gardeners and administrators.

Good

Is the service effective?

Our findings

We looked at the way people's needs were assessed and planned for, prior to them using the service. We asked some people how they were involved with this process they said, "I did come for a visit before arriving. We did have a meeting about me when I arrived," "I'd heard about this place before I came. I did get worried and at first it was a mess, but it's getting better" and "It was really strange coming here from where I was. I was told what this place was like, but it did take me a while to settle in."

The registered manager described the process of initially assessing people's needs and abilities before they used the service. This involved meeting with the person and completing a holistic needs assessment, by gathering information from them and any relevant health and social care professionals. We looked at records which showed wide-ranging needs assessments had been carried out, including individual risk assessments. The processes included obtaining the person's views about the service. People were encouraged to visit the service, for meals activities and short stays. This was to actively support the ongoing assessment process and provide people with the opportunity to experience the service before moving in. The registered manager said the process included taking into consideration the person's compatibility with people already using the service. The service had policies and procedures to support the principles of equality and human rights. This meant consideration was given to protected characteristics including: race, sexual orientation and religion or belief.

We looked at how consent to care and treatment was sought in line with legislation and guidance. During the inspection, we observed examples where staff consulted with people on their individual needs and preferences and involved them in routine decisions. Staff spoken with told us they routinely consulted with people about their lifestyle choices and asked for their consent before delivering care. The care records we reviewed included signed and dated agreements on consent to care and treatment. People spoken with also indicated they were involved with their care plans and had signed in agreement with them. During the inspection we discussed with the registered manager, best interest approaches around consent arrangements for night time monitoring.

We checked whether the service was working within the principles of the Mental Capacity Act 2005 (MCA) and whether any conditions or authorisations to deprive a person of their liberty were being met. The 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 possible, people make their own decisions and are helped to do so when needed. When they lack mental 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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

Processes were in place to assess and monitor people's capacity to make specific decisions about their care, treatment and lifestyle choices. There was information to demonstrate appropriate action had been taken to apply for DoLS authorisations in accordance with the MCA code of practice. Records had been kept to

monitor and review the progress of pending applications. Policies and procedures had been devised and introduced to provide guidance and direction on meeting the requirements of the MCA. Staff spoken with indicated an awareness of the MCA and DoLS, including their role to uphold people's rights and provide care and support in the least restrictive way possible. They told us how they supported and encouraged people to make their own decisions. One staff member was designated as DoLS coordinator; this helped ensure the principles of the MCA were applied.

We checked how people were supported to eat and drink in order to maintain a balanced diet. People spoken with had mixed views about the quality and variety of food provided. Their comments included, "The food is okay," "Sometimes it's not hot enough" and "It's okay but not always what I like." However, all the people we spoke with felt they could discuss their meals and what they liked to eat. We spoke with the head chef who told us new menus had recently been introduced and updated. There was a four-week rotating menu system. The main meal was served at lunchtime and three choices were routinely offered. The menus we looked at showed a balanced variety of meals were offered. The menus were displayed across the service and were available for people to refer to. The head chef indicated they were keen to consult with people about any dissatisfaction they may have and their suggestions for improvements. We therefore discussed ways of achieving this.

Information was recorded about people's individual dietary requirements, the support they needed and any risks associated with their nutritional needs. This information had been shared with kitchen staff who were aware of people's dietary needs, likes and dislikes. Processes were in place to check people's weight at regular intervals. This was to help monitor risks of malnutrition and support people with their diet and food intake. Health care professionals, including GP's, speech and language therapists and dieticians were liaised with as necessary. Specific diets were catered for. The head chef had expertise in producing blended food in an appealing and appetising way. Health care assistants spoken with had awareness of nutritional matters and described how they aimed to promote healthy eating and balanced diets.

Mealtimes were flexible and people could eat in their rooms if they preferred. We saw people enjoying the mealtime experience as a social occasion. We also observed examples of people being sensitively supported and encouraged by staff with their meals. The meals looked plentiful, well presented and appetising. Drinks were available and offered throughout the day. Some people were involved in cooking their own meals and made drinks and snacks for themselves, some also had their own fridges and tea and coffee making equipment. However we discussed ways of further supporting people to make drinks independently in The House.

Meals were cooked and prepared in the main building and transported to the units by use of an insulated trolley. We observed this method in practice and considered it could detract from people's meal time experience. However we found a 'nutrition and dining' audit process had recently been introduced. This involved an observational evaluation of people's experience at mealtimes; we noted any actions for improvements had been identified and planned for. The registered manager confirmed more suitable means of effectively transporting the food were being sought.

We looked at how people were supported to live healthier lives. One person spoken with said, "Staff take me to the doctors when I need to go. They do look after me here." People were offered the opportunity for physical exercise, including walks and exercise classes. We discussed with the register manager the value of including 'physical fitness' as a specific area of need in the care plan process. People's medical histories, mental health diagnosis and healthcare needs were included in the care planning process. Their physical and emotional wellbeing was monitored daily and considered as part of ongoing reviews. This meant staff could identify any areas of concern and respond accordingly. Records were kept of healthcare

examinations/checks, visits from healthcare professionals and appointments in the community. This included consultations with GPs, nurse practitioners, speech and language therapists, opticians, dentists, podiatrists, psychiatrists and care coordinators. The provider had enrolled the services of an occupational therapist and a consultant psychiatrist to review people's needs and provide guidance and support. A Nurse Practitioner from the local GP surgery attended the service twice each week and liaised with the GPs about minor ailments and ongoing health conditions. People had 'hospital passports' to share important and personalised information when they accessed health care services. The service had recently produced policies and protocols on managing people who may self-neglect their care and who were reluctant to receive attention and treatment from healthcare agencies.

We looked at how the provider made sure that staff had the skills, knowledge and experience to deliver effective care and support. People we spoke with were not aware of the staff training and development programme. However one person told us, "Staff seem to know what they are doing."

Staff spoken with described the training they had received and said that learning and development was ongoing at the service. Processes were in place for new staff to complete an initial 'in-house' induction training programme. This included an introduction to the service, familiarisation with policies, procedures and health and safety matters. We spoke with one staff member who confirmed they had completed the induction training. It was policy of the service to recruit staff with recognised qualifications in care. However we discussed with the registered manager the value of utilising the Care Certificate training programme as refresher training for long qualified staff. The Care Certificate is a nationally recognised set of standards that health and social care workers adhere to in their daily working life.

The provider's mandatory training programme included: infection prevention and control, dignity in care, basic life support, moving and handling, health and safety, fire safety, MCA and DoLS, mental health, learning disability, dementia, equality, diversity and human rights. We looked at the staff training matrix and a sample of certificates which confirmed training had been completed. Health care assistants had a Level 2 or above, NVQ (National Vocational Qualification) or were working towards a level 2 or 3 Diploma in Health and Social Care. Housekeeping staff had been supported to attain an NVQ in cleaning. Qualified nursing staff were supported to continue and update their professional development.

Staff spoken with indicated they had supervision sessions with a member of the management team. We saw records confirming individual supervision meetings had been held. The meetings had provided the opportunity for two-way discussions on the staff's role, responsibilities and any concerns. We noted from the schedule of staff supervisions and appraisals, that several were overdue. However it was apparent the registered manager had identified this shortfall and plans were in place to make improvements and monitor progress.

We reviewed how people's individual needs were met by the adaptation, design and decoration of premises. We looked around the premises and noted furnishings, carpets and decoration were of a satisfactory standard. We found people had been encouraged and supported to personalise their rooms with their own belongings. They had been enabled to choose their own colour schemes and make shared decisions on furnishings for communal areas. This had helped to create a sense of 'home' and ownership.

We reviewed how the provider used technology and equipment to enhance the delivery of effective care and support. The activities centre had a computer suite and electrically adjustable height kitchen equipment for people using wheelchairs. The service had internet access to enhance communication and provide access to relevant information. This included: sending and receiving e-mails and supporting people to have on-line contact with families and friends. E-learning formed part of the staff training and development programme

and policies and procedures were accessible via computer software.

Good

Is the service caring?

Our findings

We reviewed how the service ensured that people were treated with kindness, respect and compassion and how they were given emotional support when needed. Most people spoken with made positive comments about the staff team and the care and support they received. They said: "Staff are there for me, and I trust them," "Staff are very caring," "Staff support me a lot," I do talk to staff if I don't understand" and "They are really good. I feel better when I listen to them. " We observed meaningful and positive interactions between people using the service and staff. Staff showed sensitivity and consideration when responding to people's needs. A commissioner of service told us that on a recent review, "All [four] clients advised that they were very happy with their care."

Staff had been provided with training on dignity as well as equality and diversity. Equality is about championing the human rights of individuals or groups of individuals, by embracing their specific protected characteristics and diversity relates to accepting, respecting and valuing people's individual differences. The consensus from conversations with people was that staff understood their needs. They indicated staff had enough time to spend time with them and that there was a consistent team of regular staff, with some use of agency workers.

We checked how the service supported people to express their views and be actively involved in making decisions about their care and support. Everyone had a care plan which identified their individual needs and preferences and how they wished to be supported. The care assessment process took into consideration people's personal history, cultural needs, family history, relationships, religion, hobbies and interests, likes and dislikes and lifestyle preferences. This information was used to influence and shape their individual care plans, to highlight their needs and expectations, and how they wished to be supported. Most people spoken with indicated they had been actively involved in compiling their care plans and care reviews. One person told us, "I go to the planning meetings. We talk about what's best for me and it's good."

People indicated they were happy with the approach and attitude of staff at the service. All those spoken with felt that staff treated them respectfully. We saw instances where staff were respectful and kind when supporting and encouraging people with their daily living activities and individual lifestyles. Staff spoken with knew people well and understood their role in providing people with person centred care and support. They indicated they had time to provide care and support, also to listen to people and involve them with decisions. Staff were aware of people's individual needs, specific routines, backgrounds and personalities. They gave examples of how they supported and promoted people's individuality and choices. One healthcare assistant told us, "Everybody is different. They may have different views, but they are not treated any less for being different. We treat all people with respect." The service had a 'keyworker system.' This linked people using the service to a named staff member who they worked more closely with. The main aim of the 'keyworker system' was to develop more trusting and beneficial relationships.

We asked people if the support they received promoted their independence. They described how they had been enabled to develop independence skills, by accessing the community resources and doing things for themselves and others. They said, "They try to get me to do as much as I can for myself," "I work in the

garden" and "I am given a lot of freedom." During the inspection, we observed people doing things independently and making their own decisions, some with staff support. Promoting choices and encouraging independence was reflected in the care plan process. Staff spoken with explained how they encouraged independence, in response to people's individual abilities, needs and choices. One staff member said, "We try to encourage people to do as much for themselves as possible."

There were a number of notice boards around the service. These provided a range of information for people to access, including various 'self-help' leaflets, proposed activities, forthcoming events and the details of local advocacy services. Advocates are independent from the service and can provide people with support to enable them to make informed decisions. One person told us, "I have used an advocate here, and staff have helped me." There was a guide to Heightside House Nursing Home, which provided people with details of the services and facilities available. We noted the service's CQC rating and the previous inspection report were also on display. This was to inform people of the outcome of the last inspection.

People had free movement within the service and grounds and could choose where to spend their time; however there were some expectations around respecting each other's privacy. There were seven bedrooms which could be used for double occupancy. However, at the time of the inspection only two rooms were shared and this arrangement was under review. We noted privacy screening was provided in shared rooms. Some bedrooms did not have suitable locks to effectively promote privacy; however we were assured this matter was to be addressed. We saw staff respecting people's private space by knocking on doors and waiting for a reply before entering. Staff described how they upheld people's privacy within their work, by supporting people sensitively with their personal care needs and maintaining confidentiality of information.

Requires Improvement

Is the service responsive?

Our findings

People told us they received care that was responsive to their needs and personalised to their wishes and preferences. People spoken with said, "If I tell someone, they do listen and ask how they can make things better. I feel that helps me," "They know me and know how to help me," "Staff help me to do things that I want to do" and "They have always listened to what I've said and we fix things that way."

People had individual care and support plans, which had been developed in response to their needs and preferences. All the people we talked with were aware of their care plans. For example, one person said, "I do get involved with my care plan at meetings. I'm invited and listened to." We saw the care and support plans were divided into sections in response to areas of need and were underpinned by a series of risk assessments. We found examples of care plans which were sensitively and clearly written. The information identified people's needs and provided guidance for staff on how to respond to them. It was apparent the plans were reflective of people's preferences and there was evidence to confirm most people had been consulted on the content. There were also records of reviews with the involvement of others, including care coordinators, psychiatrists and social workers.

However we found some shortfalls in care plan records, including unclear information and a lack of detail around people's specific care and support needs. We noted the care plan process didn't routinely include people's aspirations. One person told us, "I'm not sure about the future. I don't think about it. It doesn't come up to talk about." We discussed with the registered manager the value of enabling people to identify their aspirations, in order to support them in working towards their hopes and ambitions. We also noted care reviews were not consistently carried out in accordance with the provider's timescales. For instance some reviews had not been completed for over three months. The registered manager had already identified these shortfalls and had taken action to make improvements.

Records were kept of people's daily living activities, their general well-being and the care and treatment provided to them. There were also additional monitoring records as appropriate, for example relating to behaviours and specific health care needs. There were 'hand over' discussion meetings between staff to communicate and share relevant information. These processes were to enable staff to monitor and respond to any changes in a person's needs and well-being.

People indicated they were mostly satisfied with the range of planned activities offered at Heightside House. The notice boards displayed information about forthcoming events, such as church services, various outings, residents meetings and a programme of daily activities. People had been actively supported on a one to one basis and in groups to attend community events and chosen leisure activities. One person commented, "We go out a lot." We found positive and meaningful relationships were encouraged. People were actively supported as appropriate, to have contact with their family and friends. The on-site activities centre provided resources for rehabilitation and skill development. There were computers for people to use, which meant they could improve and develop their IT skills. People were enabled and supported to complete domestic tasks such as laundry, cooking, baking and cleaning. One person explained, "Staff have helped me and do help me a lot." We discussed with managers and staff specific examples of the progress

people had made, resulting from the service being responsive and developing ways of working with them. A commissioner of services indicated that their clients were happy to be at the Heightside House, they described how people were actively supported to maintain their recovery by sharing responsibility for daily living activities.

We checked if the provider was following the Accessible Information Standard. The Standard was introduced on 31 July 2016 and states that all organisations that provide NHS or adult social care must make sure that people who have a disability, impairment or sensory loss get information that they can access and understand, and any communication support that they need. We found people's individual communication needs, abilities and preferences were highlighted and responded to in the care planning process. People spoken with indicated an awareness of the content of their care plans. However, we noted this written information was produced in a conventional style. We therefore discussed with managers ways of presenting written material, including care plans and important policies, in a more 'user friendly' format which would help with meeting the expectations of the Accessible Information Standard.

We reviewed how people's concerns and complaints were listened and responded to and used to improve the quality of care. The people we spoke with freely expressed their views and opinions on their experiences at the service. This provided a good indication that the culture of the service encouraged people to be comfortable and confident in speaking up. Everyone told us they knew how to make a complaint and how to contact the service provider. A commissioner of service told us each of their clients were aware of who to speak to if they had any concerns, but all had stated they were happy and had no concerns.

The complaints procedure was summarised in the guide to the service and was displayed on various notice boards. This information provided guidance on how to make a complaint, along with an indication of how concerns would be managed. Complaints forms were available around the service for people to complete. Staff spoken with expressed an understanding of their role in responding to and supporting people to make complaints.

We reviewed the complaints management processes. Records were kept of the date, nature of the complaints and action taken. Records showed slow progress had been made in resolving one outstanding/repeated complaint. Another more recent complaint was in the process of being investigated and resolved in consultation with the person raising the concern.

Processes were in place to respond to comments' including people's minor concerns and grumbles. This included responding to any dissatisfaction expressed within residents meetings, individual reviews and consultation surveys.

All the people spoken with told us that residents' meetings were held. They said that during the meetings, staff kept them informed of any changes that might be happening. This had provided the opportunity for people to make suggestions, be consulted and make shared decisions. We noted from the records of meetings we reviewed that various matters had been raised and discussed including menus, activities and changes to the accommodation. However, we received some comments from people which suggested improvements were needed with the how the meetings were managed. People said, "We have meetings, but when we say something, nothing happens." "The staff run them, it's not our voice," "Not many people speak and it's really led by staff telling us things. I don't really understand it" and "I am valued and people do listen, sometimes though it seems slow to get anything changed."

People did have opportunities to be consulted and make their views known, through satisfaction surveys. At the time of the inspection, this process was under review. We discussed with the nurse responsible for the

consultation surveys, further ways of ensuring the process valued and empowered people's contribution/suggestions for improvements at the service.

We recommend the service pursues further ways of empowering people to be included in making decisions which affect their lives.

We evaluated how people were supported at the end of their life to have a comfortable, dignified and pain-free death. People's end of life wishes and preferences were agreed, recorded and reviewed as part of the advanced care planning process. Six staff had had completed the Six Steps to Success in End of Life Care training to help ensure they were able to provide the appropriate care. The service worked with other agencies as appropriate, when responding to people's specific needs. The service had policies and procedures to guide an appropriate response to care of the dying and people's advanced decisions.

Inadequate

Is the service well-led?

Our findings

At our last two inspections we found the provider did not have proper oversight of Heightside House and there was a lack of effective systems for checking, improving and developing the service. At this inspection we found some improvements had been made. Representatives of the provider visited the service quarterly to and complete reports on their findings. The reports following the visits were available at the service and included action plans for improvements. However, there was a lack of robust evidence to demonstrate how the provider was assured of the quality and safety at the service and how they monitored and ensured the progression of identified improvements. There were no strategic business/action plans available from the provider, to steer a clear vision and direction on the ongoing development of the service. These shortfalls resulted in failings of the provider for the third time; we have therefore rated this outcome as inadequate.

We checked if the monitoring systems ensured that responsibilities were clear and that quality performance, risks and regulatory requirements were understood and managed. Arrangements were in place for regular audits and checks to be carried out on processes and systems. However, we found shortfalls in assessing and managing risks for the well-being protection and safety of people who used the service. We also found some improvements were needed with planning and delivering person centred care and empowering people. Some of these matters were proactively responded to during the inspection process. But we would expect such shortfalls and matters for development to be identified and addressed without our intervention.

The provider had failed to ensure their auditing and quality assurance systems were effective in mitigating risks to people's wellbeing and safety. We also found processes were not in place to demonstrate the provider proper oversight of the service. This was a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People we talked with did not express any concerns about the overall management arrangements at the service. They all indicated they knew who the managers were. Their comment's included, "They know me and know how to help me" and "I talk to them all the time. It's great; they know how to help me." A commissioner of services commented, "From a commissioning perspective, Heightside provides an essential service for clients…." and a mental health care professional told us, "I feel that generally Heightside provide a good service."

The management team in place included the registered manager, deputy manager and lead nurses. The staff rota had been arranged to ensure there was always a senior member of staff on duty to provide leadership and direction. There were also administrators providing additional management support. Comments from staff included, "The managers are supportive and approachable," "I think it's well organised. The managers are accessible. There is always someone there to provide advice" and "I feel supported by the managers. They are fairly visible around the service."

The registered manager had attained recognised qualifications in health and social care. He had updated his skills and knowledge by completing the provider's mandatory training programme and through

attending relevant seminars. We were also told networking with other managers in the organisation was progressing. Throughout the inspection, the registered manager expressed commitment to the ongoing developments at the service and demonstrated a proactive response to the inspection processes. Information in the PIR showed us the registered manager had identified some matters for ongoing development over the next 12 months.

The service's philosophy of care was reflected within the written material including, the statement of purpose, job descriptions, staff induction and policies and procedures. Staff spoken with expressed an understanding of their role and responsibilities. They were aware of the management structure and lines of accountability at the service. Staff had been provided with job descriptions and a code of conduct, which outlined their roles, responsibilities and duty of care. They had access to the service's policies, procedures and any updates. Staff meetings were held on a regular basis. We looked at the records of the most recent staff meetings and noted various work practice topics had been raised and discussed. Staff spoken with told they were encouraged to make suggestions and voice their opinions during meetings.

We looked at how are people who used the service, staff and others were consulted on their experiences and shaping future developments. There were 'suggestion boxes' available to encourage people to provide ongoing feedback on the service. There were quality improvement group meetings for staff to reflect on the service provision and suggest developments. People who used the service had been given the opportunity to complete a satisfaction survey in September 2017. Responses had been collated and analysed. We found as result, action had been taken to make improvements with activities and sharing information with people on their prescribed medicines. At the time of the inspection the survey process was under review. A revised questionnaire had been compiled based upon the framework, safe, effective, caring, responsive and well-led. We discussed ways of proactively sharing the outcomes surveys and ensuing the results were embedded into the quality monitoring processes.

We evaluated how the service worked in partnership with other agencies. We found arrangements were in place to liaise with other stakeholders including: local authorities, the health authorities, and commissioners of service. There were procedures in place for reporting any adverse events to the CQC and other organisations, such as the local authority safeguarding and deprivation of liberty teams. However our records showed that notifications had not always been appropriately submitted to the CQC. We discussed this matter with registered manager who acknowledged our concerns and agreed to take action to rectify this requirement. Following the visit we received retrospective notifications on specific incidents. We continue to monitor the service's compliance with this requirement.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were not protected against the risks to their health, safety and wellbeing.(Regulation 12 (a) (b))

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to ensure their auditing and quality assurance systems were effective in mitigating risks to people's wellbeing and safety. Processes were not in place to demonstrate the provider proper oversight of the service.