

Four Seasons (Bamford) Limited

Heywood Court Care Home

Inspection report

Green Lane
Heywood
Rochdale
Lancashire
OL10 1NQ






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17 December 2015

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Ratings

Overall rating for this service

Requires Improvement 

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

Summary of findings

Overall summary

This was an unannounced inspection which took place on 17 December 2015. The service was last inspected on 04 July 2014 when we found it to be meeting all the regulations we reviewed.

Heywood Court Care Home is a purpose built detached home close to the centre of Heywood. Accommodation is provided over three floors. The home is registered to provide accommodation and personal care for up to 45 people. On the day of our inspection 36 people were living at the home.

The service had a registered manager in place at the time of our inspection. 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.

During this inspection we found that the service had a whistleblowing policy in place. This was accessible to staff and gave clear steps for them to follow should they need to report poor practise.

We looked at the staffing levels within the service. We found that whilst sufficient numbers of staff were employed, the deployment of these throughout the service was not always safe.

Medicines, including controlled drugs, were stored securely and only authorised and trained staff members had access to them.

There were robust recruitment processes in place within the service. Records we looked at showed that all necessary checks had been undertaken prior to a new staff member commencing employment.

We looked at records relating to the evacuation of people in an emergency situation. We saw people had Personal Emergency Evacuation Plans (PEEP) in place but found these were not person centred. We have made a recommendation in relation to the personal emergency evacuation plans (PEEPs) in place for people who use the service.

We saw equipment was available throughout the service to support people with limited or no mobility. Records we looked at showed that staff members had received training in moving and handling.

Staff told us and records we looked at showed that staff members had to undertake an induction when commencing employment at Heywood Court Care Home. Mandatory training and shadowing experienced staff members were also part of the induction process.

Records we looked at showed that where the service considered someone lacked capacity, capacity assessments were undertaken and the relevant people were involved. Best interest meetings were also held for those people who lacked capacity to make certain decisions.

The service did not always follow the principles of the Mental Capacity Act (2005). We have made a recommendation that the service considers the MCA in relation to Lasting Powers of Attorney and ensures that people's rights are protected.

We found that people who were susceptible to urinary tract infections were not being encouraged to drink extra fluids. We spoke with the registered manager regarding this and the matter was addressed during our inspection.

People who used the service had access to a range of healthcare professionals in order for their health needs to be met. This included GP's, district nurses and tissue viability nurses.

We saw communal areas were thoughtfully decorated and bedrooms had been personalised with items that people had brought with them.

We observed interactions from staff members that were calm, respectful and valued people who used the service. People who used the service told us that staff were kind and nice to them.

Staff had completed training in understanding end of life care in dementia and person centred approaches in end of life. We saw that people who used the service and their relatives were involved in the development of end of life care plans.

The service had an activities coordinator in place. We saw activities on offer included memory games, movies, loom knitting, days out, trips to the local shops, dancing and Blackpool illuminations.

We checked our records before the inspection and saw that accidents or incidents that CQC needed to be informed of had been notified to us by the registered manager.

There were robust quality assurance systems in place which looked at areas such as health and safety, maintenance, laundry, kitchen and infection control. Night visits were also completed by the registered manager.

The service had improvement plans in place which covered refurbishment throughout the service. During our inspection we saw that some of the work had been completed.

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.

Staff we spoke with told us they had received training in safeguarding adults and felt able to report any concerns of abuse with the registered manager.

Risk assessments had been completed for health related issues to keep people safe.

We found some bathrooms did not have waste bins for the disposal of paper towels as per best practice guidance.

Is the service effective?

Requires Improvement 

The service was not always effective.

Staff we spoke with told us they received supervisions and appraisals on a regular basis. They also felt able to approach the registered manager at any time.

There was ample signage throughout the service to support people living with dementia to orientate themselves to the environment and promote independence.

The service did not always follow the Mental Capacity Act (2005). Care records indicated that people had lasting powers of attorney in place; however there was no evidence to suggest if this was in relation to financial matters or health and welfare. This meant people's rights were not always protected.

Is the service caring?

Good 

The service was caring.

People who used the service and relatives told us that staff members were kind and caring. We observed interactions that were respectful and valued people.

Relatives of people who used the service told us they were contacted by the service if their loved ones condition changed.

Records we looked at showed that end of life had been discussed with people who used the service and their relatives. Care plans were in place for those people at the end of their life.

Is the service responsive?

Good ●

The service was responsive.

The service had an activities coordinator in place. We saw that activities on offer included, hairdressers, memory games, movies, puzzles, crafts, concerts, trips to local shops and Blackpool illuminations.

Care plans we looked at were fully reflective of people's current support needs. Regularly reviews of care plans were undertaken and changes identified.

People who used the service told us they were able to make choices such as, getting up when they wanted, going to bed when they wanted and if they wanted support.

Is the service well-led?

Good ●

The service was well led.

Staff told us and records showed that staff meetings were held on a regular basis. We saw topics of discussion included service users and staff sickness.

Policies and procedures were in place for staff to follow. These were accessible for staff and provided them with guidance in their roles.

The service had improvement plans in place. We saw that some of the work had already been undertaken on the day of our inspection.

Heywood Court Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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.

This inspection took place on 17 December 2015 and was unannounced.

The inspection team consisted of one adult social care inspector, a specialist advisor who was experienced in older persons care 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 service.

Before our inspection we reviewed the information we held about the service including notifications the provider had made to us. This helped to inform us what areas we would focus on as part of our inspection. We had requested the service to complete a provider information return (PIR); this is a form that asks the provider to give us some key information about the service, what the service does well and improvements they plan to make. We received this prior to our inspection and used the information to help with planning.

We contacted the local authority safeguarding team, the local commissioning team and the local Healthwatch organisation to obtain views about the service. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. Healthwatch informed us that they had not received any feedback relating to Heywood Court Care Home. The local commissioning team shared their recent quality assurance findings with us which helped to inform us on specific areas we would focus on during our inspection.

During the inspection we carried out observations in all public areas of the home. We spoke with five people who used the service, three relatives and one visiting professional. We also spoke with three staff members, an activities coordinator, cook, laundry worker, administrator, deputy manager, registered manager and regional manager.

We looked at the care records for five people who used the service and the personnel files for three staff

members. We also looked at a range of records relating to how the service was managed. These included training records, quality assurance systems and policies and procedures.

Is the service safe?

Our findings

People who used the service told us they felt safe. Comments we received included, "It's a pleasant place and the home is safe. Nobody pushes me about or bosses me", "I have been looked after", "I am not left on my own", "I feel safe and comfortable here", "I feel safe here because there is staff to look after me. I never feel bullied, the staff listen to me and try to make me comfortable" and "I feel safe in here. The girls are very nice".

Relatives we spoke with also told us they felt their family members were safe. Comments we received included, "[Relative] is safe here", "I think he is safe. There is always staff keeping their eye on him. The garden is secure and he goes in the garden regularly. The care he gets is also safe. I have no concerns about his care" and "The doors of the home are secure and enough staff are there to observe his safety. I know all his needs are being met".

Within the entrance to the service was a safeguarding notice board. This contained the safeguarding adult's policy, management of feedback policy, safeguarding matters and the local authority safeguarding policy. Telephone numbers were also made available for staff and visitors to use should they have any safeguarding concerns.

The service had a safeguarding adult's policy, this gave staff clear examples of the types of abuse and signs that they needed to observe for and report on. The service had reported any safeguarding issues in a timely manner to the local authority and the Care Quality Commission.

Staff we spoke with told us they had received training on safeguarding and were able to tell us how they would identify signs of abuse and told us they felt confident in reporting any concerns of abuse with the registered manager. Records we looked at confirmed care staff had received training in safeguarding as part of their mandatory training requirements.

We saw the service had a whistleblowing policy in place which gave staff clear steps to follow should they need to whistle blow (report poor practice). Staff we spoke with told us they were aware of the whistleblowing policy and knew what to do if they had any concerns. They told us they would approach the registered manager or another member of the management team and felt confident to do so.

We examined five care files during our inspection. We saw that risk assessments had been completed for health related issues such as moving and handling, falls and nutrition. The risk assessments were completed to keep people safe and not restrict what they wanted to do. People who used the service, or where necessary a family member, were involved in any decisions that were made.

We saw risk assessments had been completed for the environment such as the Christmas tree lights, working at height, use of bed rails and display screen equipment. This showed the service had considered the health and safety of people using the service.

We looked at the management of medicines within the service. We checked the systems for the receipt, storage, administration and disposal of medicines. We also checked the medicine administration records (MARs) for a number of people who used the service.

People who used the service told us, "I think I have medication in the mornings and they give me a drink with them. I think the tablets are to keep me calm. I more or less get them at the same time. If I wanted to know what the tablets were I would just have to ask", "I am not on any medicines", "I am not on a lot of medicines" and "I don't remember when they give them to me". One person told us their medicines "Are to help me breathe I think, I do not want to know what they are for. If I asked staff they would tell me".

Relatives we spoke with told us, "[Relative] gets them regularly and at the right time" and "[Relative] is given covert medication which she seems to be taking. There has been a best interest meeting about covert medication which I attended along with my mum".

Only senior care staff that had completed medicines training were permitted to administer medicines within the service. Competency checks were undertaken by the registered manager on an annual basis to ensure that staff remained competent to administer medicines. Records we looked at showed medicine audits were undertaken within the service on a monthly basis. There was a staff signature list for staff to be accountable for their practice should an error be detected.

We saw the service had a medicines policy and procedure in place which was under review. This provided staff members with information about the management of medicines and included information on the storage, recording, disposal and ordering of medicines. We saw this was available in the treatment room. We saw patient information leaflets were available and we were told people who used the service were encouraged to read these.

Medicines, including controlled drugs, were stored securely and only authorised, suitably trained senior care staff had access to them. There was a procedure in place for the handing over of medicine keys. Medicines that required storing in a fridge were correctly stored. Regular temperature checks of the fridge were undertaken on a daily basis to ensure correct storage. Regular temperature checks were also completed within the room to ensure medicines were stored at recommended temperatures.

We noted all the Medication Administration Records (MAR) contained a photograph of the person for whom they were prescribed; this should help ensure medicines were given to the right person. Staff members recorded the times medicines were given and all entries were clear and legible.

We checked to see that controlled drugs were safely managed. We found records relating to the administration of controlled drugs (medicines which are controlled under the Misuse of Drugs legislation) were signed by two staff members to confirm these drugs had been administered as prescribed; the practice of dual signatures is intended to protect people who use the service and staff from the risks associated with the misuse of certain medicines.

We found robust recruitment processes were followed by the registered manager when recruiting new staff. We saw the provider had a policy and procedure to guide them on the relevant information and checks to be gathered prior to new staff commencing; ensuring their suitability to work at the service.

We examined the files for three staff members. We saw the service obtained written references from previous employers and an application form (where any gaps in employment could be investigated) had been completed. The service undertook a criminal records check called a disclosure and barring service (DBS)

check prior to anyone commencing employment in the service. The DBS identifies people who are barred from working with children and vulnerable adults and informs the service provider of any criminal convictions noted against the applicant.

People who used the service told us there was enough staff to meet their needs. Comments we received included, "There's always somebody knocking about and I have not had to wait for attention. I have not seen anybody waiting for help", "There is enough staff and I haven't waited for help. There is always staff I can ask for help", "There is enough staff to look after everybody" and "There is enough staff and people don't wait for help, there is always staff around".

Relatives we spoke with told us "There seems to be enough staff on duty. Residents don't seem to have to wait for help" and "There is enough staff on duty to meet his needs. There is a notice board in the entrance with the names of staff on duty and it has always been the correct number. There is always staff around". We spoke with staff about the staffing levels within the home. They told us they felt there was enough staff on duty and that the registered manager regularly supported the team when it was needed. The registered manager told us the service used a staffing level assessment tool; 'Care Home Equation for Safe Staffing' (CHESS) to determine the staffing levels required throughout the service. On the day of our inspection we saw there were seven care staff members on duty; five staff was working on the ground floor and two staff members were working on the top floor.

The service had a business continuity plan in place, instructing staff on how to deal with emergency situations such as fire, flood, loss of power and influenza epidemics. This should ensure that staff members were able to deal with emergency situations safely and effectively.

We saw that all the gas and electrical equipment had been serviced and checked. This included the fire alarm system, electrical installation, gas appliances, portable electric appliances, fire extinguishers and emergency lighting. Hot water outlet temperatures were checked to ensure they did not scald people. Windows had a suitable device fitted to prevent people who used the service from falling out accidentally and radiators did not pose a threat to people's welfare.

We looked at all the records relating to fire safety. We saw weekly inspections were undertaken of means of escape, emergency lighting, fire alarm, fire exits and a visual check of firefighting equipment. Fire control panels and fire doors were also checked on a weekly basis. The training matrix showed that fire safety training was mandatory and staff had completed this.

The service undertook weekly fire drills and recorded the names of staff members that had been involved in them. We saw personal emergency evacuation plan (PEEP) assessments were located in care files. However these were not person-centred and did not identify individual's mobility issues and how people were best supported in an emergency situation. We recommend the service considers contacting the local fire service for further advice on current best practice guidance in relation to PEEP's.

The service had a policy and procedure in place for the reporting of accidents and incidents. This had been issued in April 2013 and was due to be reviewed in July 2015. There was no evidence that this review had been completed and this contained out of date information. The policy did not recognise the recent change in the reporting of injuries/specific incidents and that are to be reported to the Care Quality Commission.

The service had a falls prevention file in place. This contained a quarterly falls analysis which identified how many falls had occurred in specific time frames, where they had occurred and details of the injury. We saw that as a result of these measures had been put in place to reduce the risk, for example staff had been

directed to encourage one person to spend more time in communal areas. These records also showed that for people that had fallen three times a referral to the falls team was to be made. This showed the service was actively attempting to reduce the amount of falls that occurred.

Relatives we spoke with told us they had observed their family members being assisted with moving and handling. Comments we received included, "[Relative] has to be hoisted. Two staff members do the hoisting" and "I have seen staff using the hoist. They seem to do that properly".

We saw equipment was available to support people who had limited or no mobility. Mechanical hoists, wheelchairs and walking aids were available to help people with their mobility. Mechanical hoists were inspected on a regular basis by an external company and deemed appropriate and safe for use.

Records we looked at showed that care staff had received training in moving and handling and people who used the service had moving and handling risk assessments in place. These detailed what equipment staff were required to use and the level of support required to ensure people's safety at all times.

We asked people who used the service if they thought the service was clean. Comments we received included, "I think it is clean in here, I have seen them cleaning. My bedroom is clean and the bedding is clean", "It is clean in here, there are lots of people keeping it clean" and "It's a very clean place".

Relatives we spoke with told us they felt the service was clean. Comments we received included, "It is clean in here. Staff are always cleaning. Staff clean my relative's bathroom and bedroom every day. I've never smelled any bad smells", "[Relative] clothes are kept clean and she is kept tidy", "It is clean and smells fresh. The staff use a lot of sprays. [Relative] bedding is kept clean".

"[Relative] medication is given at the same time each day" and "The home is clean. The family are here at different parts of the day and see staff using the correct equipment and procedures for cleaning".

One visiting professional told us, "I haven't noticed the home is dirty and there is no permanent bad odour".

We found the service had an infection control policy in place which was up to date. The policy covered areas such as the prevention of cross infection, hand washing, protective clothing and laundry management. There was hand washing facilities around the building for staff to use and prevent the spread of infection. Staff had access to protective clothing such as gloves and aprons and we saw staff using the equipment throughout our inspection. Training records we looked at showed that staff had undertaken training on infection control. During our observations around the service we found that some en-suite bathrooms did not have a bin in place to discard of paper towels after hand washing. Best practice guidance suggests that foot operated waste bins should be available for the disposal of paper towels.

Is the service effective?

Our findings

People who used the service told us they were supported by staff members who knew them well. Comments we received included, "The staff know how to handle people" and "They look after me properly". One relative we spoke with told us, "The staff seem to know what they are doing".

Throughout the inspection we observed interactions between staff members and people who used the service. We saw that staff knew people well, including what their likes and dislikes were.

We looked at the induction and training of staff within the service. Staff we spoke with and records we looked at showed that staff completed an induction when commencing employment at Heywood Court Care Home. One staff member told us, "I had a good induction period of about four weeks".

Records we looked at showed that care staff members had to complete an initial two day induction. This covered topics such as an orientation to the service, service users, staffing, policies and procedures, training and health and safety. The new staff member was also expected to undertake practical tasks during day two of their induction. Mandatory training and shadowing were also included as part of the induction process. The registered manager told us that the company were looking to introduce the new Care Certificate which would also be used as part of the induction process.

Relatives we spoke with told us they felt that staff were well trained. One relative told us, "Staff are well trained. I have seen them undergoing supervised training". Records we looked at showed that training was available in a numbers of ways including online and face to face. Staff had completed training in areas such as food handling and hygiene, safeguarding, Mental Capacity Act, end of life care and moving and handling. We also saw that future training had already been identified for all the staff members.

Staff we spoke with told us they received regular supervisions and appraisals. One staff member told us they had supervisions every 3 months; however they felt they were able to discuss any concerns or ask for support whenever they needed to. Records we looked at showed systems were in place to ensure staff received regular supervision and appraisal. Supervision meetings helped staff to discuss their progress at work and also discuss any learning and development needs they may have.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. Then they lack mental capacity to take particular decisions, any made on their behalf must be in their best interest and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were

being met.

Staff we spoke with told us and records we looked at showed that they had received training in Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS). The service also had a policy and procedure in place in relation to MCA and DoLS at the time of our inspection which was accessible to staff.

Records we looked at showed that people had been assessed in relation to their capacity. These assessments had been undertaken by the relevant and appropriate people and had involved the person and their family. We also saw that best interest meetings had been undertaken for those people who lacked capacity to consent. A 'best interest' meeting is where other professionals, and family if relevant, decide the best course of action to take to ensure the best outcome for the person using the service. We saw that the service had involved external health professionals in their decision making process and acted in the best interest of the person being assessed.

Prior to our inspection we reviewed our records and saw that DoLS applications, which CQC should be made aware of, had been notified to us in a timely manner. The service had submitted 36 DoLS applications and for those that had been authorised a record was kept to identify when these would expire. This ensured that people who used the service were not being unlawfully deprived of the liberty.

A number of care records we looked at documented that relatives had Lasting Power of Attorney's (LPA) in place. However, there was no evidence to suggest if these were in place to make decisions in relation to financial matters or health and welfare. None of the care records we looked at contained copies of LPA's or confirmation that these had been seen and what decisions relatives could legally make on a person's behalf. This meant that people's rights may not always be protected. We recommend the service considers the MCA and other relevant guidance in relation to Lasting Power of Attorney's to protect the rights of people who use the service.

People who used the service told us they had access to healthcare professionals. Comments we received included, "I have seen a doctor here, I remember being checked over. I have been very well here", "It is a while since I saw a doctor when I had something wrong with my hand" and "Staff would get a doctor if I needed one. I have not seen a doctor recently that I can remember".

Relatives we spoke with told us their family members had access to healthcare professionals. Comments we received included, "[Relative] had bad legs at one time and the district nurse came and put cream on. They are better now", "[Relative] has seen a doctor recently for her arthritis and chest", "I have mentioned health concerns which have been dealt with immediately", "He recently saw a GP and he has had his eyes tested in the home" and "[Relative] has made small steps towards allowing other health care professionals to see him".

One visiting professional told us, "There is good staff response when a GP is needed at any time".

Records we looked at showed people had access to a range of healthcare professionals in order for their health care needs to be met. These included GP's, district nurses, community mental health team and tissue viability nurse. We saw that people were weighed on a regular basis and people who used the service told us, "I am weighed regularly" and "I am weighted about once per month".

We asked people who used the service what they thought of the food. Comments we received included, "The food is very good, I like the food", "I don't like or dislike the food. It is just there", "I like a good breakfast.

I usually have porridge and toast. I can have egg and bacon. I like the breakfasts here. However one person told us, "They don't offer a choice of food but I have enjoyed the food. I like plain food" and another told us, "I eat everything I am given. I like more or less everything. Staff don't give me a choice, I eat what they put in front of me".

Relatives we spoke with told us, "The food seems to be okay. [Relative] is not on any special diet. She has put weight on in the last eight months she has been here" and "He likes hot cross buns and pears for breakfast which we bring in and staff give to him".

We looked at how people were supported in meeting their nutritional needs. We were told that people could have what they wanted for breakfast, this included a choice of cereal, toast and cooked breakfast. We saw that people had a choice of two main courses at lunch time. We observed a care staff member taking two plates of food to one person so that they could choose what they wanted. This is good practice and shows an alternative way of giving people choices when they do not understand verbally. Food was well presented and looked appetising. We also observed that drinks were available in communal areas at all times for people to help themselves to.

We observed the lunch time meal on the top floor of the service. We saw that the two staff members took it in turns to leave the top floor to go down to the kitchen regularly for reasons such as to collect the food or drinks trolleys. This left one person to serve the meals and support people who required assistance to eat. We noted that four people had been given their meals, half an hour had passed and they still had a large amount of food left before being supported; at which point the food was likely to have been cold. We discussed this with the regional manager and registered manager who told us they would immediately look at ways to ensure this did not happen again. The regional manager spoke with us before we finished our inspection and evidenced that they had requested a telephone point to be installed in the kitchen so that staff could ring for items they required rather than leaving the floor. In the interim two mobile phones were to be purchased so contact could be made. We were also assured the deployment of staff would be looked at during meal times. This showed the service was responsive to concerns raised.

Records we looked at also showed that one person was susceptible to urine infections and staff were to complete a fluid chart when drinks had been accepted and offered. On the day of our inspection the service was awaiting results of a urine test to confirm if the person had a urine infection. However the fluid chart we looked at showed the person had received a total amount of 400mls of fluid from rising at 6am until checking at 3pm. We discussed this with the regional manager and registered manager who could not explain why fluids were not being encouraged despite a urine infection being suspected. This was immediately addressed. A jug of juice was placed in the room and staff were instructed to encourage fluids when undertaking regular checks on the person. The regional manager showed us evidence that they had requested face to face training for staff on the importance of hydration. We have confidence that this will be addressed.

Within the main area of the service was a notice board which contained photograph's of all the staff members who worked at Heywood Court Care Home. This supported people who used the service as well as family members and visitors to recognise staff members.

We noted signage throughout the service to support people living with dementia to remain independent and enable them to recognise different areas of the service. For example, bathrooms and toilets contained pictorial signs and photographs of people at the side of their bedroom door to support people to locate their own rooms.

Bedrooms we looked at provided ample space for people to be able to personalise them. In some rooms we noted people had brought their own sofas in from home and most rooms had photographs and personal ornaments. This showed the service encouraged people to make their rooms as homely and comfortable as possible.

We saw communal areas had been thoughtfully decorated. In one lounge we noted it had been decorated to resemble a library and another lounge had a full wall decorated in wallpaper that resembled a forest. One person sat in this lounge told us they liked the wallpaper that much that they had attempted to sketch it themselves.

Is the service caring?

Our findings

We asked people who used the service if staff were caring. Comments we received included, "The girls are nice when they help me", "Staff will sit down and talk to people. I must say staff have been very good to me, they are kind and we often have a joke", "The staff are alright. I don't want staff to sit and talk with me", "The staff are all very nice", "Staff are good" and "Staff are very kind and I have got friends here too. The girls are very polite".

Relatives we spoke with told us, "Staff are approachable", "I think there is good interaction between residents and staff", "Staff make me welcome" and "Staff will sit down and chat with residents. They are kind and caring and make me feel welcome".

One visiting professional told us, "Care has improved a lot here. I have observed staff with relatives and they are very supportive".

We observed that staff members' approach was calm, respectful and valued people. They explained options and offered choices using appropriate communication skills. People appeared comfortable and confident around the staff.

People who used the service told us their privacy and dignity was respected. Comments we received included, "I can take my relatives to my room if I want privacy" and "Staff respect my dignity".

Relatives told us, "They do try to respect her dignity" and "They treat my relative with respect. He is not just a number".

The service had identified staff members who were 'dignity champions'. These staff members were responsible for ensuring people who used the service had adequate personal items, such as toiletries and clothing. Likewise if staff members noticed people were short of items they would approach the dignity champions to address this.

The service had a vending machine in place which contained personal items such as deodorant, shower gel, shaving foam etc. that people could purchase if they required. All items were priced reasonably and in line with supermarket prices. This meant that should someone require an item immediately it could be purchased from the vending machine.

People who used the service told us they were encouraged to remain as independent as possible. Comments we received included, "I wash and dress myself when I can", "I get dressed myself" and "They do let me manage things I can do on my own".

Relatives we spoke with told us that staff contacted them as and when required. One person told us "Staff do contact us if anything for his care changes". Records we looked at confirmed that relevant people were contacted when a person's needs had changed.

We found that confidential information was not always protected. We noted a cupboard located next to one of the lounges had a keypad lock fitted, however this was unlocked and accessible. This contained personal information relating to people who used the service. Information relating to people who use the service should be kept securely and only accessible to those people who need the information. We were assured that the door to this room was always kept locked and this had been a mistake by the last person to enter.

We spoke to people who used the service about the atmosphere in the service. Comments we received included, "There's nothing I don't like here" and "It is like being on holiday living here". Relatives we spoke with told us, "I can come at various times of the day. I have been when it's evening and I don't feel I have to leave" and "I think he is happy here".

One staff member we spoke with told us, "I love my job, the hours I work are family friendly and I feel part of a good team". We found the atmosphere in the service was warm and friendly. We saw that staff had time to sit and talk to people who used the service and respond to people in a timely manner.

We looked at records relating to end of life. We saw that staff had completed training in understanding end of life care in dementia and person centred approaches in end of life care. Care files we looked at evidenced that end of life discussions had taken place and care plans were in place to show what people's wishes were at the end of their life. These records showed that the person and their family members had been involved in the process.

One visiting professional told us, "We have a few end of life patients here over the last few months. We attended because there is no RGN (Registered Nurse) here and we supervise the overall nursing needs. The end of life care here is exceptional. Staff pay a great deal of attention to pressure areas, mouth care, bowels etc. they are very good".

Is the service responsive?

Our findings

We spoke to people who used the service regarding activities within the service. Comments we received included; "If the weather is fine staff take me for a walk to the newspaper shop. I buy a newspaper and sometimes sweets. I am a fresh air man myself and if it is fine they let us sit in the garden", "I have been to a concert this week. Children entertained us. All the young ones brought us a cup of tea. I enjoyed the children fussing over me, it was brilliant. The home's bus took us and brought us back", "There is a television room and I like watching the soaps like Corrie and Eastenders. I love watching football on television", "Staff will do things like play games with me. We go into the garden in summer", "We do have occasional dances. I have also been to Blackpool to see the lights" and "The staff did bring a dog to the home. I enjoyed that". One person also told us, "I would like to go to the pub for an odd drink or two as a social occasion".

Relatives we spoke with told us, "I have seen staff dancing with her and I know staff have taken residents out on trips. The home has its own mini bus" and "Today [Relative] is out in the garden sweeping up leaves. He likes to be active but not take part in organised activities. He does like singing and dancing. Also he likes to help in the dining room or clearing pots. He has friends amongst residents in the home and he likes to visit them and give them a couple of sweets". However one relative told us, "She is in her room far too often and left on her own". We spoke with the registered manager regarding this and were informed that this person spends their days between the main lounge and bedroom. Records we looked at confirmed what the registered manager told us and that occasional bed rest was also required.

We spoke with the activities coordinator during our inspection. They told us they had worked in the service for three years and had recently attended a companywide meeting for activity coordinators. They told us, "I found this very useful. I learned about ways of fund raising, interaction with resident's and one to one activities". We were also told that activities were arranged on an individual basis according to their needs. For example, the activity coordinator had asked the maintenance person to make inter fitting plastic plumbing pipes so one person could fit them together.

We observed an activity board was displayed in the main corridor on the ground floor. Activities we saw on offer included; memory games, movies, loom knitting, hair salon, puzzles and Christmas crafts. We also saw that rummage boxes were available on the ground floor and top floor. These contained items such as balls, soft toys and musical instruments. On the day of our inspection the hairdresser was in the service and a Christmas Fayre was advertised. We also observed one person was having their nails painted, in the designated 'nail bar' area.

Activities that people had been involved in were recorded in their care records and also in a journal that was located in their own bedrooms. This meant that family members could see what activities their relative had been involved in.

Records we looked at showed that prior to moving into Heywood Court Care Home a pre-admission assessment was undertaken. This provided the manager and staff with the information required to assess if Heywood Court Care Home could meet the needs of people being referred to the service prior to them

moving in.

We asked people who used the service if they had been involved in the developing of their care plans. One person told us, "I have not seen anything written down like a care plan but staff do ask me about things I like or don't like". One relative we spoke with told us, "Staff have shown me her care plans".

The care records showed that risks to people's health and well-being had been identified and plans were in place to help reduce or eliminate the risk. We saw the care plans were reviewed regularly by staff to ensure the information was reflective of the person's current support needs. We also saw evidence in the care records that either the person who used the service and/or their family had been involved in the care planning and decision making. People also had a 'My Choices Booklet' in place. This contained their life history, what a good day and a bad day might have looked like, preferences, religious needs and what activities the person liked to do. However this information was not always reflective within some care plans. This meant there were missed opportunities for some care plans to be person-centred.

People who used the service told us they were given choices. Comments we received included, "Staff don't ask me about choices but I like sitting here", "I get up when I want. Staff usually come to check on me about half past seven and tell me breakfast is ready", "Staff tell me if they are going to do something. I like to get up early. Staff come and wake me up and get me dressed. It suits me to get up then", "I like to go to bed late and get up late" and "The girls come and get me up. If I want to get up the staff help me if I need it".

Relatives told us, "My relative chooses when he gets up and goes to bed" and "My relative prefers a strip down wash. He did this at home and it has continued here". However, one relative told us "I would like [relative] to have more baths". We spoke with the registered manager about this and they informed us that people could have baths when they wished.

Care records we looked at showed that people's religious and cultural needs were taken into consideration. Religious care plans were in place to identify people's wishes in this area. Records we looked at showed that one person liked to see the vicar and that this had occurred in recent times.

People we spoke with told us they had never made a complaint. Comments we received included, "I would tell staff if I was not satisfied. I have never made a complaint" and "I have no complaints about here".

One relative we spoke with told us, "I have no complaints but I think if I had the manager would listen. The manager does take notice of what is said". However, another relative told us, "When I have raised concerns I am not sure the staff have acted on them. I have spoken to the manager and I'm not at all sure he does anything".

The service had a complaints, concerns and compliments policy in place dated 25 March 2015. This covered areas such as managing feedback and the complaints process to be followed. We looked at the complaints book. We saw that complaints had been signed and dated as acknowledgement of receipt but noted that the remainder of the process was completed electronically. Part of the procedure in relation to complaints was the learning from these and this was a standard agenda item with the regional home manager's meetings. We did not see any evidence of this during our inspection.

The service had a handover file in place. This contained daily information relating to the well-being of people who used the service that required passing on through the staff team. All entries we looked at had been signed by both the day staff and night staff as confirmation that they had read and understood the entries. This should ensure that staff are kept up to date in relation to important information.

Is the service well-led?

Our findings

The service had a manager who registered with the Commission on 03 September 2014. 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 a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We asked people who used the service if they knew who the manager was. Comments we received included, "I don't know who the manager is. I don't know who runs the place but I am quite happy that it is run well", "I don't know who the manager is. I think this place is run well, I can't complain at all" and "They have a man and a woman manager".

Relatives we spoke with told us, "I know who the manager is. We are on first name terms", "I know the manager and have spoken to him. He is a 'hands on' manager. He has staff meetings and organises relative's meetings. He runs a good home".

On the day of our inspection we were made very welcome by the registered manager and staff members. We observed the registered manager interacting with visitors, relatives and people who used the service in a friendly and personalised manner. The registered manager was able to speak in great detail about all the people who used the service.

During our inspection we spoke with the deputy manager. They told us they had not been in post for long and had been promoted into the position. They told us, "I have a lot to learn, the manager supports me well and the rest of the team". We also spoke with relatives about the leadership within the service. One person told us, "Things have improved to what they were".

Electronic surveys were used within the service entitled "Our Quality of Life Programme". Within the main entrance area there was an electronic tablet for people to leave feedback and complete surveys. On the notice board in the entrance the service had identified improvements that had been made as a result of feedback received. For example "You said the home needed sprucing up by decorating and new soft furnishings, so we bought new blinds, bought a new coffee table, commenced decorating lounges and bedrooms and bought new lounge chairs". This showed the service was responsive to feedback and keeping people informed.

Records we looked at showed that relatives meetings were undertaken. A copy of the last meeting held on the 03 November 2015 was on display on the notice board in the main entrance to the service for people to read. We saw that topics discussed included advocacy, events and entertainment in the service.

Staff told us and records showed that staff meetings were held on a regular basis. Minutes of these showed who had attended and what had been discussed. We saw topics of discussions included people who used the service, managing staff sickness and managing challenging behaviour. Staff told us they were able to

bring up items for discussion and felt able to do so.

We checked our records before the inspection and saw that accidents or incidents that CQC needed to be informed about had been notified to us by the registered manager. This meant we were able to see if appropriate action had been taken by management to ensure people were kept safe.

We looked at the quality assurance systems in place within the service and found that these were sufficiently robust to identify areas for improvement. The audits we looked at included health and safety, maintenance, fire safety, premises, kitchen, laundry and infection control. Records also showed that the registered manager completed night visits to conduct further audits. Further in-depth audits are also undertaken by the company's own quality facilitators.

There were policies and procedures for staff to follow good practice. We looked at several policies and procedures which included recruitment, safeguarding, infection control, whistle blowing and complaints. These were accessible for staff and provided them with guidance to undertake their role and duties.

We spoke with the registered manager to enquire how the service focussed on improvements. We were shown improvement plans to cover the period 2015 to 2017 which included the refurbishment of the service, including new bathrooms, replacing window frames, new carpets and work to the exterior of the building. We saw that some of the work had already been completed on the day of our inspection.