Care Quality Commission

Pearl Care (Norwich) Limited

Heatherside Care Home

Inspection report

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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?	Requires improvement
Is the service well-led?	Good

Overall summary

This inspection was unannounced and took place on the 7, 8 and 12 October 2015.

Heatherside is a care home which provides residential care for up to 34 older people who have a range of needs, including those living with epilepsy, diabetes and dementia. The care home comprised of two floors set within two acres of grounds. At the time of the inspection 33 people were using the service.

People told us that whilst they felt safe they were having to wait long times to receive assistance. People were not always getting their bathing needs met which was confirmed by care staff. There were not always enough suitably skilled and competent care staff deployed to meet people's needs in a timely fashion.

Recruitment procedures were not fully completed in order to protect people from the deployment of unsuitable care staff. The provider had not ensured that a full employment history had been obtained from care staff. This is required to make sure care staff can explain

Summary of findings

any gaps in employment when they have been working with adults who are vulnerable. The provider had however obtained character and professional references to check care staff's suitability for the role.

People living with specific health conditions such as diabetes were not always being monitored effectively. Records showed that people with persistent high blood glucose levels were not monitored as frequently as required. People were not referred to appropriate healthcare professionals in a timely manner when high levels of blood glucose levels were documented.

People using the service told us they felt safe. Staff understood and followed the provider's guidance to enable them to recognise and address any safeguarding concerns about people.

People's safety was promoted because risks that may cause them harm had been identified and managed. People were supported by care staff who encouraged them to remain independent. Appropriate risk assessments were in place to keep people safe.

Senior care staff responsible for supporting people with their medicines had received additional training to ensure that people's medicines were being administered, stored and disposed of correctly.

People were supported to eat and drink enough to maintain a balanced diet. People told us they were able to choose their meals and they enjoyed what was provided. Records showed people's food and drink preferences were documented in their care plans and were understood by the chef. People at risk of malnutrition and dehydration were assessed to ensure their needs were met. However, records for people who required food and fluid chart monitoring were not always completed fully. As a result it could not always be identified whether people were eating and drinking sufficient to maintain their health.

Care staff underwent the provider's own induction process when they started work at the home. Staff had been required to undertake training in a number of areas although this was not the industry standard induction process. Guidance on implementing a nationally recognised induction and training package had been sought before the inspection. Care staff had been encouraged to undertake professional qualifications. Care staff also worked with experienced care staff prior to delivering care to assess their ability and confidence before delivering care independently. A recommendation has been made for the provider to implement the care certificate induction and training package for all care staff.

People were supported by care staff to make their own decisions. Staff were knowledgeable about the requirements of the Mental Capacity Act (MCA 2005). The service worked with people, relatives and social care professionals when required to assess people's capacity to make specific decisions for themselves. Care staff sought people's consent before delivering care and support. Documentation showed people's decisions to receive care had been appropriately assessed, respected and documented.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. An appropriate application had been submitted to the relevant supervisory body to ensure that one person living at the home was not being unlawfully restricted.

Care staff demonstrated they knew and understood the needs of the people they were supporting. People told us they were happy with the care provided. The registered manager and care staff were able to identify and discuss the importance of maintaining people's respect and privacy at all times. People were encouraged and supported by care staff to make choices about their care including how and where they spent their day.

People had care plans which were personalised to their needs and wishes. They contained detailed information to assist care staff to provide care in a manner that respected each person's individual requirements. Records showed that relatives were encouraged to be involved at the care planning stage, during regular reviews and when their family members' health needs changed.

People did not always know how to complain but told us they would be happy to do so if required. Procedures were in place for the manager to monitor, investigate and respond to complaints in an effective way. People, relatives and care staff were encouraged to provide feedback on the quality of the service during regular meetings with care staff and the manager as well as the completion of customer satisfaction questionnaires.

Summary of findings

The provider's values and philosophy of care were communicated to people and available to care staff. Care staff did not always know what these meant for them but people told us, and we saw, these standards were evidenced in the way that care was delivered.

Heatherside did not have a registered manager in post. The service is required by a condition of its registration to have 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. A new manager had been appointed by the provider 11 weeks before the inspection and were in the process of becoming registered with the CQC.

The provider had a regular monitoring quality monitoring process in place to assess the quality of the service being provided however this was not always effective in identifying areas for improvement. When areas for improvement had been identified actions had been taken promptly to ensure the on-going quality of the service provided.

The manager and care staff promoted a culture which focused on providing individual care which was dignified and respectful. People were assisted by care staff who were encouraged to raise concerns with the manager.

Care staff told us they felt supported by the manager.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires improvement

The service was not always safe.

The provider did not obtain a full employment history of all care workers. The provider had not identified if care workers had any unexplained gaps in their employment which might have made them unsuitable to deliver care.

The provider did not ensure that people were supported by adequate numbers of skilled and competent care staff.

People were safeguarded from the risk of abuse. People had confidence in the service and felt safe and secure when receiving support.

Contingency plans were in place to cover unforeseen events such as a fire at the home to ensure people's continuity of care.

Medicines were safely stored and administered by senior care staff who had received appropriate training which they repeated on a yearly basis to ensure their competency.

Is the service effective?

Requires improvement

The service was not always effective.

People were supported to eat and drink enough to maintain their nutritional and hydration needs. Staff knew people's preferences regarding food and drink and this was documented in care plans.

Care staff undertook the providers induction process and worked with experienced members of care staff before delivering care to ensure they had the skills, knowledge and confidence required to deliver effective care.

Risks to health, safety or well being of people who used the service were not always addressed appropriately. Records showed that people living with diabetes were not monitored as regularly as their care plans identified. People with diabetes were not always referred for further healthcare professional advice in a timely manner.

People were supported to make their own decisions and where they lacked the capacity to do so staff ensured the legal requirements of the Mental Capacity Act (MCA) 2005 were met. Staff understood the principles of the MCA 2005 and understood the Deprivation of Liberty Safeguards (DoLS).

Is the service caring?

Good

The service was caring.

People told us that care staff were caring. Care staff were motivated to develop positive relationships with people.

Summary of findings

People were encouraged to be actively involved in making decisions about their care, treatment and support which included how they wished to spend their day. Advocacy guidance and information for people to seek additional support with their decision was made available in people's service user guides.

People received care which was respectful of their right to privacy whilst maintaining their safety.

Is the service responsive?

Requires improvement

The service was not always responsive.

The provider had not ensured the availability of meaningful activities at the weekends to prevent people becoming socially isolated, people told us there was nothing for them to participate in.

Records showed people were encouraged to participate in creating their personal care plans. Relatives and those with legal authority to represent people were involved in planning and documenting people's care. This ensured that people's needs and preferences were taken into account when developing their care plans.

People's needs had been appropriately assessed. Care staff reviewed and updated people's risk assessments on a regular basis, additional reviews were held when people's needs changed.

People were encouraged to make choices about their care which included their participation in activities and where they wished to spend their time at the service.

There were processes in place to enable people to raise any issues or concerns they had about the service. Any issues, when raised, had been responded to in an appropriate and timely manner.

Is the service well-led?

Good

The service was well led.

The home had been without a registered manager since April 2015. Care staff had experienced a number of managerial changes which had led to them feeling unsettled and unsupported previously. A new manager had been appointed 11 weeks before the inspection and was in the process of becoming registered with the CQC.

The provider regularly monitored the quality of the service provided through quality assurance audits to identify where improvements could be made to the home. These however were not always effective in all identifying areas which required additional improvement. When areas were identified they were actioned in a timely manner to improve service provided.

Care staff were aware of their role and now felt supported by the new manager. Care staff told us they were able to raise concerns and felt the manager provided good leadership.

Summary of findings

The manager promoted a culture of high quality and person centred care. People and relatives were provided with the opportunity to provide feedback to the manager and provider to allow for continuous improvement.

Heatherside Care Home

Detailed findings

Background to this inspection

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

This inspection took place on the 7, 8 and 12 October and was unannounced. The inspection was conducted by two inspectors and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who use this type of care service; on this occasion they had experience of family who had received residential care. The Expert by Experience spoke with people using the service and their relatives.

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

During the inspection we spoke with 15 people, six visitors, two senior care staff, three care staff, the chef, the activities coordinator, the administrative assistant, maintenance member of staff, the manager and the regional manager for the provider. We looked at eight care plans, five of the same people's daily care records, five care staff recruitment files, care staff training records and 11 medicine administration records (MARS). We also looked at care staff rotas for the dates 7 September to 5 October, quality assurance audits, the provider's policies and procedures, complaints and compliments and records of staff, visitor and resident meetings. During the inspection we spent time observing staff interactions with people including lunch time sittings.

The service was previously inspected on the 30 December 2014 and no concerns were raised.

Requires improvement

Is the service safe?

Our findings

The majority of people we spoke with told us they felt safe living at Heatherside. One person said, "I feel safe, if you are not well there are staff to look after you". Another person said, "I am safe here, the staff are very good". Relatives we spoke with said they felt their family members were safe, one relative told us, "She (family member) is safe in here," another relative told us, "He (family member) is perfectly safe in here".

Despite people feeling safe the provider did not always obtain full employment histories from care staff before they started to work at the location to ensure they were suitable to deliver care. The provider could not identify if care workers had a history of working with adults who were vulnerable and that any gaps in this employment could be reasonably explained.

The provider did not ensure that full employment histories were provided by care workers prior to commencement of delivery of care. This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care staff had undergone other recruitment checks as part of their application and these were documented. These records included evidence that pre-employment checks had been made including obtaining written previous work and personal character references. Recruitment checks also included a Disclosure and Barring Service (DBS) check. The DBS helps employers make safer recruitment decisions and helps prevent the employment of staff who may be unsuitable to work with people who use care services.

During the inspection people and care staff raised concerns that staffing levels were not always sufficient to meet people's needs. Records showed that people's dependency levels had previously been assessed by the manager in March and August 2015. During this process specific criteria was used to identify the correct number of care staff required to meet people's needs safely.

Assessments of people's needs completed in August 2015 identified there were no people at the home who required two members of staff to provide all aspects of their personal care. Records in a care plan showed however that on the 5 August 2015 a person had been assessed as requiring two members of care staff to deliver all their personal care. At the time of the inspection the manager told us that another resident, in addition to the above, had recently had a change in their health needs. This also placed them as high dependency requiring two members of care to support the safe delivery of their care. Care staff levels had not been reassessed to reflect these people's additional support needs. During the inspection we saw that care staff were not always available to assist people who required two person care. One person had been left lying in their bed in an uncomfortable position and a member of care staff said they were unable to help them at that time.

The manager told us that the home had historically deployed four care staff in the morning, three care staff in the afternoon with two awake members of night staff. The night care staff would be supported by an additional member of night care staff who would sleep but was available if required. Care staff rotas identified that on 10 occasions in September and in October, due to sickness, the manager had not been able to deploy the minimum level of staffing at night. Care staff told us that not having an additional night support worker meant there would be a delay for people who woke early being assisted to prepare for their day.

Care staff told us they were able to meet people's most important needs such as toileting, eating and drinking by prioritising people's care. Care staff told us however, and we saw, that people were not always having their bathing needs met when they wanted. During the inspection one person who had requested a shower was still sat in their dressing gown awaiting assistance at lunchtime but care staff were too busy to assist. This person then dressed for dinner and was provided with a shower the following day.

People told us they were not always receiving the care they required at the time they requested. One person told us, "I wait 15 minutes or so before anyone comes (after ringing their call bell) I can usually wait". Other people told us they experienced a delay when they had requested help after pressing their call bell, "Sometimes I wait a long time when I press my bell especially if I want to go to the toilet", another person told us, "I wait a long time in the evenings, no one comes". Another person said, "Sometimes I wait a long time, they (care staff) are very busy". An electronic call bell system was in place however there was no ability to monitor care staff response times when people had requested assistance. This meant the provider could not effectively monitor care staff response times to ensure

Requires improvement

Is the service safe?

there were enough staff deployed to meet people's needs safely. The manager had recognised the need for additional care staff deployment and the day prior to the inspection the requirement of extra care staff had been requested of the provider. Steps were being taken since the inspection to recruit additional care staff to ensure sufficient care staff were deployed to meet people's care needs.

The provider did not ensure that there were sufficient numbers of suitably competent, skilled and experienced care staff deployed to meet people's needs at all times. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care staff were able to demonstrate their awareness of what actions and behaviours would constitute abuse and provided examples of the types of abuse people could experience. Care staff were also able to describe physical and emotional symptoms people suffering from abuse could exhibit. Care staff were knowledgeable about their responsibilities when reporting safeguarding concerns.

People were protected from the risks of abuse because care staff understood the signs of abuse and the actions they should take if they identified these. The provider's policy provided guidance for care staff regarding how and when to raise a safeguarding alert. This is a concern, suspicion or allegation of potential abuse or harm or neglect which is raised by anybody working with people in a social care setting. Care staff had received training in safeguarding adults and were required to refresh this training annually.

Risks to people's health and wellbeing were identified and guidance provided to mitigate the risk of harm. All people's care plans included their assessed areas of risk for example, mobility, nutritional, pressure area risk and people's moving and handling needs.

Risk assessments included information about action to be taken by care staff to minimise the possibility of harm occurring to people. For example, some people using the service had restricted mobility due to their physical health needs. Information was provided in their care plans which provided guidance to care staff about how to support them to mobilise safely around the home and when they were being transferred.

Care staff understood these risks and were observed supporting people in a manner which ensured people's safety. Records showed people had received the appropriate treatment which followed their risk management plans. Risks to people's care were identified, documented and care staff knew how to meet people's needs safely.

There were robust contingency plans in place in the event of an untoward event such as accommodation loss due to fire or flood. Personal Emergency Evacuation Plans (PEEPs) were in place for people living at the location. These provided an easy guide for care staff and emergency personnel in regards to the assistance people required due to their mobility and health needs in the event of a fire. Care staff knew the fire drill procedure and this had been practised to confirm their understanding of the actions to take. If rooms were no longer suitable for living in then people would be moved to the provider's other homes to ensure continuity of care. These plans allowed for people to continue receiving the care they required at the time it was needed.

Arrangements were documented for the safe storage, administration and disposal of medicines. Senior care staff involved in the administering of medicines received training to ensure they did so safely. Senior care staff were required to successfully complete yearly medicines training to retain this role. Records confirmed this was occurring. This training was to ensure that senior care staff's knowledge was current and updated regularly.

There were clear arrangements in place to ensure that people were protected from receiving the wrong medicines. Medicines were mostly administered using a monitored dose system from a blister pack. This is where medicines are placed into individual boxes for each person to be taken at the specified times. People's medication administration records (MARs) documented what medicines were required, the reasons for administration and the right method, for example orally. We observed senior staff administer medicines safely using the correct method of administration.

There was a medicine fridge which was kept at the appropriate temperature for storage. Records confirmed that on occasions there had been days where this had not been documented daily however there were no excessively high or low levels recorded indicating it was not working correctly. All medicines were stored securely in a locked cabinet which was secured to a wall in a locked medicines room. Medicines stocks were checked and correctly corresponded with the stocks recorded. Some prescription

Requires improvement

Is the service safe?

medicines are controlled under the Misuse of Drugs Act 1971; these medicines are known as controlled drugs or medicines. They are subject to stringent storage conditions which were being met. Controlled medicine stock levels were correct and audited daily to ensure they corresponded with the controlled medicines records.

Where people were able to self-administer their medicines this was risk assessed appropriately, suitable locked medicines storage was provided and this risk assessment was reviewed monthly.

People received their medicines safely because senior care staff were trained and competent to administer medicines and followed safe procedures to manage people's prescribed medicines.

Requires improvement

Is the service effective?

Our findings

A majority of people we spoke with were positive about the ability of the care staff to meet their care needs. People said that they felt care staff were well trained and had sufficient knowledge and skills to deliver care. One person we spoke with said, "They (care staff) are very good".

All care staff new to the service, regardless of previous experience were required to complete the provider's induction before delivering care.

The provider used an induction and training programme to prepare care staff for their role however this was not a nationally recognised programme. The induction and initial training provided by Heatherside included a guided tour of the home, introduction to residents and the care team, teaching of manual handling techniques and an introduction to the policy and procedures file. This was followed by five or six shadow shifts before care staff would be deployed to deliver care. Shadowing is where new care staff are partnered with an experienced member of care staff as they perform their job. This allows new care staff to see what is expected of them. Care staff said they could ask for an extension of this shadowing period if they had not felt confident.

The area manager told us that the provider had recently had a training input on the Care Certificate and was training people to act as Care Certificate competency assessors. These care staff would then have responsibilities to oversee the implementation of the Care Certificate. The Care Certificate is a nationally recognised set of standards of care which care staff need to meet before they can safely work unsupervised.

Records showed that care staff had not always received refresher training at the time specified as necessary by the provider. Although training had not always been refreshed in accordance with the provider's guidance, care staff were able to demonstrate their knowledge and understanding of key subjects such as safeguarding. A number of care staff were due to complete NVQ level 2 and 3 qualifications in social care which was supported by both the manager and the provider. On the first day of the inspection an assessor was present to ensure that those care staff who wished to register were able to do so which was supporting their on-going professional development.

It is recommended that the provider implements the Care Certificate Standards as a method to guide induction and training that is required by new care staff as per Regulation 18(2)(a) of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

Care staff were not receiving regular documented supervisions and appraisals with the manager and the senior care staff. Supervision and appraisals are processes which offer support, assurances and learning to help care staff development. Care staff we spoke with could not recall attending regular supervisions or having an annual appraisal with senior care staff or the manager.

There had been a change of manager at the location and the new manager had been in the location for eleven weeks before the inspection. Despite not receiving regular documented supervisions all care staff spoke positively about the support they received from their colleagues, senior care staff and the new manager. Care staff told us they were able to seek the manager's attention at any stage for an informal supervision discussing personal and professional advice and felt supported as a result. The manager was reviewing the system of supervision and was going to prioritise those who had not received one recently. Care staff had not always received the appropriate support and supervisions however were able to raise and discuss concerns with their colleagues and manager.

People living with diabetes were not always referred to health care professionals when required. Care plans we reviewed identified three persons living with diabetes. Only one of these people had both specific diabetes care plan and risk assessment in place although all persons had detailed actions required by care staff to maintain their health.

One person's care plan stated that their blood sugar levels should be recorded twice a day but this had not always been happening. Records identified a number of gaps in September's recording. Care staff spoken with told us that another person was due to have their blood sugar levels tested daily and that a reading of over 12 mmol/L (millimoles per litre, an international standard way of measuring blood sugar levels) was quite high. Care staff told us if there was a reading over 12 mmol/L they would

Requires improvement

Is the service effective?

test the person's blood sugar levels again later in the day to see if they remained high. Records showed that this had not happened. This person's range was from 4.6 to 22.9 during August and September.

The National Institute of Clinical Excellence (NICE) 2015 guidelines states that the normal range for an adult with Type 1 diabetes should be between four and nine mmol/L. Care plans did not display all the information required by care staff to ensure that appropriate monitoring and assessing of risks to their health could be completed.

For one person, of the 37 days tested in August and September, 32 of these days they had a reading which was higher than the recommended normal range. This person was last seen by the diabetic nurse in June 2015 and there was no record that this person had been further referred despite their persistently high blood sugar levels. Persistently high blood sugar levels meant the person was at risk of serious health complications associated with their diabetes.

The provider did not do all that is reasonably practicable to mitigate any risks to the health of people living with diabetes. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were happy with the food provided and were given the choice to eat in their rooms or in the main dining room. One person told us, "I get plenty to eat and drink" whilst another person said, "The food is good, I also get tea and biscuits so I don't need any more".

People told us that they had the food of their choice, one person told us, "They (care staff) give you a choice and if you don't like that you can have a sandwich". People were asked to choose their preferred meal choices for the following day however were able to seek alternatives at all meal times if they had changed their minds.

The chef was an agency member of staff who had been at the location for three weeks. The chef was fully aware of people who had specific dietary needs due to their diabetes or people who required a soft diet. When it had been identified that people were losing weight the manager sought healthcare professional advice and obtained fortified drinks for them to consume to support their health needs. During the inspection one person came to the kitchen and the chef demonstrated that he understood the residents' needs and provided them with a milkshake for them to enjoy. The chef told us, "I will accommodate people's choices as far as I'm concerned they're the one's I'm here for, all the time".

People were supported to make their own decisions and appropriate action was taken to ensure that people's freedom was not unlawfully restricted without authorisation. The Care Quality Commission (CQC) monitors the operation of Deprivation of Liberty Safeguards (DoLS) which applies to care homes. These safeguards protect the rights of people using the service by ensuring that if there are any restrictions to their freedom and liberty, these have been authorised by the local authority as being required to protect the person from harm. The manager had a good understanding of the DoLS which was evidenced through conversations and an appropriately submitted application. Care staff spoken with were able to identify that DoLS were required because people were not allowed to leave the home for their own safety.

When people had been assessed as lacking capacity to make specific decisions about their care the provider had complied with the requirements of the MCA 2005. The MCA 2005 is a law that protects and supports people who do not have the ability to make specific decisions for themselves. Care staff were able to identify the principles of the Mental Capacity Act 2005 (MCA 2005) and records showed they had complied with legal requirements. Appropriate guidance had been provided for care staff in care plans as to when additional assistance would be required. This included when care staff would be required to assist the person in making every day decisions. The guidance identified when a person's Power of Attorney (POA), Social Workers and relatives would have to be involved in making key life decisions. A person who has been provided with POA is there to make decisions for people when they are unable to do so for themselves.

People and relatives told us that people's consent was sought before care was delivered. One person told us, "They (staff) knock on the door and always ask (consent)". Another person told us, "They (care staff) always knock on the door and ask my consent, I don't need a lot of help". We saw that staff assisted people to make decisions and sought their consent before assisting them with their care. Care staff were able to identify how they sought people's consent from people who were unable to communicate

Requires improvement

Is the service effective?

clearly. One person was suffered with significant hearing loss and care staff were able to discuss that they would write things down for them so that they were able to agree or disagree to what action would be taken.

Good

Is the service caring?

Our findings

People experienced positive relationships with care staff. Relatives and people told us that support was delivered by caring staff. One person we spoke with told us, "They (care staff) are very good and kind". Another person told us, "They (care staff) are kind and caring, I am happy here". A visitor told us, "I think the staff are extremely kind and caring, I have never seen anything but good care". A relative said, " The staff, you can't fault them, absolutely excellent".

Reassuring and caring relationships had been developed by care staff with people. People's care plans had been written in a person centred way. Person centred is a way of ensuring that care is focused on the needs and wishes of the individual.

People's care plans included information about what was important to them such as their hobbies, how people wished to be addressed and what help they required to support them. Care staff were knowledgeable about people's personal histories and preferences and were able to tell us about people's families, previous work and hobbies.

All care staff in the home took time to engage and listen to people when they were able to do so. People were treated with dignity as staff spoke to them at a pace which was appropriate to their level of communication. Staff allowed people time to process what was being discussed and gave them enough time to respond appropriately.

Care staff told us they saw people living at the home like family and would treat them as a relative. They recognised people's needs for reassurance and care staff helped create a homely and family orientated atmosphere. One member of care staff told us, "We're their second family…This has always been a homely home…you say to care staff they're not in your house, you're in theirs, you make it what they want. You have to make the home as nice as possible". We saw care staff asking to give people hugs when they looked upset and engaging in friendly conversation. Whilst care staff were busy they continued to treat people with respect and showed a genuine care for people's wellbeing.

People who were distressed or upset were supported by care staff who could recognise and respond appropriately to their needs. One person repeatedly expressed their desire to return home and was unable to understand that they were to remain in Heatherside for their safety. This person's care plan stated that when upset to remind this person that Heatherside was their home and they did not need to pay for anything. During one lunchtime sitting this person requested to pay for their meal and care staff were aware of this information as they responded that everything had already been paid for which soothed them. This person was positively responded to by all care staff when they regularly and repeatedly said that they wanted to go home.

Another person was seen to be distressed during the inspection, the activities coordinator was kind, compassionate and gentle with their approach to this person. One member of care staff was able to describe how they would support people when they were distressed on a personal level, "I know one person who doesn't want you cuddling them every 5 minutes but if they get a paper cut they need a lot of TLC….you have to make (this home) as nice as possible".

The home provided information for people on when it would be appropriate and advisable to seek the assistance of an advocate. An advocate is someone who is able to support people who are unable to make key decisions in their life. This is a legal right for people over 16 who lack mental capacity and who do not have an appropriate family member or friend to represent their views. This is to ensure that any decisions were made in a person's best interest. This information was provided in the resident's pack given to all new people when they moved to the home. The care plans viewed showed that people had assistance to make key decisions however this information was available for people if required.

People were treated with respect and had their privacy and dignity maintained. People and relatives told us that they were treated with respect by the staff. A person told us, "They (care staff) listen to me". Another person told us, "They listen and respect me". Care staff were able to provide examples of how they respected people's dignity and treated people with compassion. People were provided with personal care in their rooms with the doors shut and we saw care staff knocked on people's doors awaiting a positive response before entering to assist.

People were also respected by having their appearance maintained. Attention to appearance was important to people and care staff assisted them to ensure they were well dressed, clean and offered compliments on how they looked. One person was seen to have tea stains on their

Good

Is the service caring?

cardigan whilst in the lounge during the inspection. This was noticed by a care staff member who offered to help them to change but they refused. Another care staff told us, "We treat the residents as like they're our mum, if someone is walking around with tea on them, I wouldn't let my mum do that, we all mean well".

Requires improvement

Is the service responsive?

Our findings

Not all the people we spoke with told us they were involved in creating their care plan. Two people we spoke with told us they were not aware of what a care plan was. One person told us, "I don't know anything about my care or a plan, they (care staff) don't explain what they are doing, they just do it, sometimes I feel rushed". Another person told us, "I don't know about my care, they (care staff) just do it, what is a care plan?". Records showed however that people were supported to express their views and where possible were involved in making decisions about their care and support

The provider sought to engage people in meaningful activities during the working week however no activities were available during the weekends and not all people felt like they were involved. One person told us, "There is not much to do, I read and I watch TV, I like to be quiet". Another person told us, "I sit and watch TV all day, there is no one to talk to if I go out of my room". Care staff told us that people were, "A little lost at the weekends" as they had no people available to lead and encourage participation in activities. This had been recognised by the manager and she was working with care staff to identify activities that people would be able to participate in when the activities coordinator was not working. This was important to ensure that people including those living with dementia had structure and a purpose to their day and to assist with preventing their social isolation.

Care plans detailed the need to help people participate in as broad a range of social activities as possible. Care staff were aware of the importance of involving people in activities to minimise their risk of social isolation. Care plans detailed people's particular social interaction needs. One person's care plan specified that they enjoyed listening to music and smaller group activities. We saw during the inspection that this person was encouraged to go into the smaller lounge area when music was playing. They were also asked if they wished to participate in the group activities such as snakes and ladders. The home had an activities coordinator who sought to engage people in activities and meaningful occupation.

An activities programme for a typical week was viewed which involved arts and crafts, chair exercises, pamper day, bingo, knitting club, word games, pom pom making and weaving. The visitors book also showed that there were visits from external groups such as the salvation army, pet therapy and a vicar who would attend once a month to complete holy communion.

People were also able to participate in external trips, such as trips to the local garden centre for afternoon tea. However these were few in number due to the money required to support and organise. A relative told us, "It would be nice for the residents to go out sometimes in a mini bus, the residents are encouraged to take part in activities". A Relatives Comfort Fund had been created and through the use of raffles and fund raising attempts money raised was going to be used to support further external activities.

Where people were unable to leave their rooms, or unwilling to do so, the activities coordinator visited people in their rooms. There they would conduct the group activity on a one to one basis such as an arts and crafts session for example. The manager told us that the activities coordinator had recently increased their hours from four to six hours a day to enable them to encourage more people to participate in activities. This was important to prevent people suffering from social isolation and becoming withdrawn. We saw a chair exercise session in the communal lounge which was attended by 15 people. People enjoyed the session, laughing and joking with the activities coordinator. The activities coordinator adopted a tactile approach encouraging and supporting people to become involved by using pom poms during the exercises. People taking part had varying levels of mobility however all were included.

Care staff were able to explain how they supported people to express their views and to make decisions about their day to day care. This included enabling people to have choices about what they would like to eat or how they would like to spend their day. Care plans recorded consent to care and care plans were agreed with the person's relative or nominated person such as those with POA. During the inspection a new resident was moving to the home and we could see that discussions were being held with people to see if they would be happy to involve their relatives in their care planning. Where this had been agreed relatives were involved in the process of discussing what care would be most appropriate to meet the person's needs.

Requires improvement

Is the service responsive?

People's care needs had been fully assessed and documented by the senior care staff before they started receiving care. These assessments were undertaken to identify people's support needs and care plans were developed outlining how their needs were to be met. Records showed that the care plans reflected the information which was gathered during the pre-assessment stage. People's care plans had recently been re-written for each individual. People's individual needs were routinely reviewed at a minimum of every six months and care plans provided the most current information for care staff to follow. Records showed that people's care plans and associated risk assessments were reviewed monthly to ensure they remained current. People and relatives were encouraged to be involved in these reviews to ensure people received personalised care. Relatives with a POA signed documentation to say that they would be given the opportunity to attend reviews of the planned care at 6 monthly intervals, or at the request of any significant party involved in the care.

Care staff completed a communications handover between themselves each morning, afternoon and evening. A handover was observed and included specific and detailed information about people's needs and any significant health updates. This enabled care staff who had been away from the home for any period of time to have an accurate and up to date knowledge of people and their required needs.

People were encouraged to give their views and raise any concerns or complaints. People and relatives told us that whilst they would not automatically know how to make a complaint they were confident to speak with care staff if required.

The provider's complaints procedure was available in people's service user guides which they received when they moved to the home. This listed where and how people could complain and included contact information for the provider and the Care Quality Commission. One person told us, "There is not much to complain about in here", another person said, "I have no complaints". A relative told us, "We have never had cause to complain". The manager documented complaints and these were reviewed. Four formal complaints had been received since the last inspection. These included theft of personal property, care standards and people entering other people's rooms. We saw that the complaints had been raised, investigated involving other professionals such as social workers and district nurses where necessary and responded to appropriately.

Good

Is the service well-led?

Our findings

The manager was keen to promote an open and supportive culture at Heatherside and was in the process of actively seeking feedback from people using the service, their relatives and care staff. People we spoke with were not able to recognise the manager due to being new in position but were able to identify the area manager. The area manager had provided a visible presence whilst Heatherside had experienced a change in managers. One person told us, "I think it's a very good home". A relative told us, "(The home) Is absolutely excellent, we can't fault at all". People said they were satisfied with the quality of the service provided, "I can't think of much (the home needs to improve)". Another person told us, "They (care staff) always take care of you and they always see you are OK".

At the time of the inspection the provider did not have a registered manager in post. The service is required by a condition of its registration to have a registered manager. At this inspection we found that a new manager was appointed 11 weeks before the inspection and had made an application to register with us. Additional management support had been made available to provide direction and leadership at the service when the previous registered manager left in April 2015. The area manager told us they had placed a temporary manager in place to create stability and support for people and staff during the process of recruiting a new manager.

Care staff identified that they had experienced unexpected changes with managers at the home however were looking forward to working with the new manager. Care staff told us the new manager provided personal and professional support and guidance. They told us they were able to approach her and were confident that she would be proactive in dealing with issues raised. One member of care staff had raised an issue previously with the new manager and it had been dealt with immediately. One member of care staff said, "The manager has been amazing, I can go in and ask her something and she'll say we need to do this, this and this and she'll do it". All care staff felt that the new manager was providing good leadership. Care staff told us, "Yes (the home is well led), I think it's her support to staff as well which is a big thing, that's the biggest thing we didn't have before. She wants to make it a good home as well, she wants to make it work.". Another member of care staff said, "I think it's her (manager) enthusiasm her want to be here….she has got a caring nature, it's the job for her…she has about 100 jobs going on, she's got the best intentions for every single one, she wants everything to be done, she wants the residents but she also wants her staff to be happy".

To ensure the delivery of high quality care the provider completed a number of quality assurance audits at the home. These included weekly checks such as fire alarm testing and infection control to monthly audits of the home in areas such as medication, care plans and accidents and incidents. These audits however did not always identify all the areas which required additional attention. During the inspection recruitment paperwork for new care staff and diabetes care plans were not always completed appropriately. Other quality audits completed identified areas for improvement which where then acted upon to improve the service provided. in January 2015 a quality audit identified that people's care plans did not always have a photo or pre-admission assessment on file. This information is important to ensure that agency staff, when used, are aware of who they are delivering care to and their previous medical histories which could affect their current health situation. A timescale was in place for this action to be completed by March 2015. We could see that this action had been completed as the relevant information had been included within the care plans reviewed.

The manager was keen to promote a culture which was based on people and staff feeling that they were living and working in a homely environment. The provider had a philosophy of care which was provided in people's service user guides when they moved to the home. It stated that the main aim of Heatherside was to provide an environment that all residents could regard as their home and that their needs and wishes were paramount. A separate privacy, dignity and rights of residents' policy was also included.

There was also set of written values for the service outlining the standards of care that was required of all care staff. These included the rights of people to have their privacy and dignity respected by care staff during care delivery and their everyday interactions. These values were made available to all care staff when they started working at the home. The new manager had been unable to formally embed the values of the home into the care staff supervisions processes at the time of the inspection. As a new manager they had been prioritising ensuring people's

Good

Is the service well-led?

care plans were suitable and updated to reflect people's needs. During the inspection however we could see that these values were being adhered to by all care staff. Interactions between the manager, care staff and people were friendly and informal. People were assisted by care staff who were able to recognise the importance of assisting people as an individual and putting their needs first.

The manager was keen to seek people's experiences and sought information on how they could improve the service they received. Feedback was sought from people during care plan reviews, residents and relatives meetings, care team meetings and use of a 'Carehome.co.uk" questionnaire. Carehome.co.uk is an national care home survey which allows people to submit their satisfaction on a service in a number of areas. These include people being treated with dignity, the overall standard of the home, quality of the care staff and management. Three reviews were submitted online in September and October 2015 which showed that each relative would be 'extremely likely' to recommend the home to friends and family if they needed similar care or treatment. One person commented, "Excellent home, new refurbished lounge area, food is excellent and the staff could not be better". Another person commented "From viewing the home to present day the staff here are wonderful. The carers and admin staff have always put the residents' needs first and foremost. The staff are amazing with the residents and nothing is too much trouble for them".

People were also asked to complete an annual 'The views of our Service Users' questionnaire. This questionnaire was provided to people and asked for their personal experience of living at the home. This included asking people if they had a choice of meals, if people felt safe and if they knew the complaints procedure. The most recent survey was being conducted during the inspection. The last survey received was for August/September 2014. During this review three people had stated that there were insufficient numbers of social events, activities or entertainment. As a result of this questionnaire an experienced member of staff who had worked at the home previously was employed as a full time activities coordinator. We could see that they were engaging and encouraged people to participate to the best of their ability.

A monthly safeguarding audit in May identified that half of each months falls had been happening between 8:30pm and 9:30pm in people's bedrooms. The provider completed a root cause analysis and took action to address. This included staggering the time of handovers to ensure that care staff were available on the floor during this time. As a direct result from June to September only one of 30 falls had occurred during this time period. This shows that when issues were identified, the results were examined, action taken and a positive outcome achieved.

Compliments when received were displayed on notice boards throughout the ground floor. A folder of recent compliments were reviewed. The following are a selection of those received. A relative wrote, "The care provided by the staff gave us piece of mind that she was being looked after in the best possible way, with humour and kindness". Another relative wrote, "I would like to express my sincere thanks to all the staff for their kindness, care and addition give to my relative during their time at Heatherside, it became her home. It was a comfort to know how happy and safe she felt in your hands".

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed **The provided did not ensure that full employment histories were provided by care workers prior to commencement of delivery of care.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing **The provider did not ensure that there were sufficient numbers of suitably competent, skilled and experienced care staff deployed to meet people's needs at all times.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The provider did not do all that is reasonably practicable to mitigate any risks to the health of people living with diabetes.**