Community Integrated Care

Green Heys Care Home

Inspection report

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Date of inspection visit: 28 & 29 April 2015
Date of publication: 23/06/2015

Ratings

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

Overall summary

This unannounced inspection took place on 28 and 29 April 2015.

Green Heys Care Home is a purpose built property on one level that provides accommodation and nursing care for up to 47 people who are living with dementia. Thirty nine people were living there at the time of our inspection. There are two units within the home; Blundell unit and Molyneux unit. Facilities include a large dining room located next to the kitchen and two large lounges. Smaller seating areas are located throughout the building and there is a quiet room that families can use to spend time with their relatives or to stay overnight.

There is court yard in the middle of the building and other smaller garden areas. These secure outdoor areas can be accessed from various points in the building. There is car parking to the front and side of the building. The home is located close to public transport links and local community facilities.

A registered manager was in post. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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.

Summary of findings

Families we spoke with during the inspection said their relatives were safe living at the home. They said security of the building was good.

The staff we spoke with could clearly describe how they would recognise abuse and the action they would take to ensure actual or potential abuse was reported. Staff confirmed they had received adult safeguarding training. An adult safeguarding policy was in place for the home and the local area safeguarding procedure was also available for staff to access.

Staff had been appropriately recruited to ensure they were suitable to work with vulnerable adults. People living at the home, families and staff told us there was sufficient numbers of staff on duty at all times.

Staff told us they were well supported through the induction process, regular supervision and appraisal. They said they were up-to-date with the training they were required by the organisation to undertake for the job. They told us management provided good quality training.

A range of risk assessments had been completed depending on people's individual needs. Care plans were well completed and they reflected people's current needs, in particular people's physical health care needs. Risk assessments and care plans were reviewed on a monthly basis or more frequently if needed.

Processes were in place to ensure medicines were managed in a safe way. We observed medicines being administered safely in the dining room by two nurses. Audits or checks were in place to check that medicines were managed safely.

The building was clean, well-lit and clutter free. Measures were in place to monitor the safety of the environment and equipment. The environment had been decorated and organised in accordance with the principles of a dementia-friendly environment.

People's individual needs and preferences were respected by staff. They were supported to maintain optimum health and could access a range of external health care professionals when they needed to.

Staff were trained and experienced in providing end-of-life care. The home had been assessed and accredited for the Gold Standards Framework (GSF) in March 2014. The GSF is an evidence based approach in end-of-life care and the national GSF centre provides training for all GSF programmes. Green Heys was the first care home in Sefton to achieve this care home quality award.

Staff worked closely with the local palliative care team, the GP and other community health care providers. They had particularly looked at the management of pain in conjunction with other health care providers. Through the use of appropriate pain relief for people who were living at the home, staff have seen a significant reduction in incidents and an improvement in people's well-being.

People were well supported at meal times. Families were pleased with the quality and choice of food. They said their relative's dietary needs were being met. People were weighed on a weekly basis and a weight loss of 2kg or more in a month meant the person was referred to the appropriate health professional.

Staff sought people's consent before providing support or care. The home adhered to the principles of the Mental Capacity Act (2005). Applications to deprive people of their liberty under the Mental Capacity Act (2005) had been submitted to the Local Authority.

Staff had a good understanding of people's needs and their preferred routines. We observed positive and warm engagement between people living at the home and staff throughout the inspection. A full and varied programme of recreational activities was available for people to participate in.

The culture within the service was and open and transparent. Families described the staff as caring, respectful and approachable. They said the service was well led and well managed.

Staff and families said the management was both approachable and supportive. They felt listened to and involved in the running of the home.

Staff were aware of the whistle blowing policy and said they would not hesitate to use it. Opportunities were in place to address lessons learnt from the outcome of incidents, complaints and other investigations.

A procedure was established for managing complaints and people living at the home and their families were aware of what to do should they have a concern or complaint.

Summary of findings

Audits or checks to monitor the quality of care provided were in place and these were used to identify developments for the service.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Relevant risk assessments had been undertaken depending on each person's individual needs.

Staff understood what abuse meant and knew what action to take if they thought someone was being abused.

Processes were in place to ensure the safe management of medicines.

Measures were in place to regularly check the safety of the environment and equipment.

There were enough staff on duty at all times. Staff had been checked when they were recruited to ensure they were suitable to work with vulnerable adults.

Is the service effective?

Good

The service was effective.

Staff sought the consent of people before providing care and support. The home followed the principles of the Mental Capacity Act (2005) for people who lacked mental capacity to make their own decisions.

People told us their relatives living there liked the food and got plenty to eat and drink.

People had access to external health care professionals and staff arranged appointments readily promptly when people needed them.

Staff said they were well supported through induction, supervision, appraisal and on-going training.

The environment had been developed in a dementia friendly way.

Is the service caring?

Outstanding

The service was caring.

Families consistently expressed that were happy with the care their relatives received. We observed positive engagement between people living at the home and staff.

Staff treated people with respect, privacy and dignity. They had a good understanding of people's needs and preferences.

Staff were trained and experienced in providing end-of-life care. The home was accredited for the Gold Standards Framework (GSF) in March 2014. Green Heys was the first care home in Sefton to achieve this quality award.

Staff worked closely with the local palliative care team, the GP and other community health care providers to ensure people were not in pain. Through the use of appropriate pain relief there had been a significant improvement in people's well-being.

Summary of findings

Is the service responsive?

Good

The service was responsive.

The care was person-centred and people's care plans were regularly reviewed and reflected their current needs. Families said the care was individualised and care requests were responded to in a timely way.

A full and varied programme of recreational activities was available for people living at the home to participate in.

A process for managing complaints was in place. People we spoke with knew how to raise a concern or make a complaint. Meetings were held at the home for people living there and their families. A satisfaction survey was conducted on a six monthly basis.

Is the service well-led?

Good

The service was responsive.

The care was person-centred and people's care plans were regularly reviewed and reflected their current needs. Families said the care was individualised and care requests were responded to in a timely way.

A full and varied programme of recreational activities was available for people living at the home to participate in.

A process for managing complaints was in place. People we spoke with knew how to raise a concern or make a complaint. Meetings were held at the home for people living there and their families. A satisfaction survey was conducted on a six monthly basis.

Green Heys 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 was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This unannounced inspection of Green Heys Care Home took place on 28 and 29 April 2015.

The inspection team consisted of an adult social care inspector and an expert by experience with expertise in services for older people. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before our inspection we reviewed the information we held about the home. This usually includes a Provider Information Return (PIR) but CQC had not requested the provider (owner) submit a PIR. A PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We looked at the notifications and other information the Care Quality Commission had received about the service. We contacted the commissioners of the service to see if they had any updates about the home.

During the inspection we spoke with one person who lived at the home and seven family members who were visiting their relatives at the time of our inspection. In addition, we spoke with the registered manager, an assistant manager, a registered nurse, three care staff, the chef, the maintenance person and the housekeeper.

We looked at the care records for four people living at the home, three staff personnel files and records relevant to the quality monitoring of the service. We looked round the home, including some people's bedrooms, bathrooms, dining rooms and lounge areas.

Good

Is the service safe?

Our findings

Due to needs associated with memory loss, most of the people living at the home were unable to verbally share with us whether they felt safe living at the home and whether they felt safe in the way staff supported them. One person did say they felt "as safe as I can be" living at the home. All family members we spoke with were pleased with the security of the home. A family member said, "They [staff] change the code numbers on the doors and the numbers are kept confidential. I would say it's a very safe environment." Another family told us, "The home is on one level and the doors have to be opened by a member of staff."

The staff we spoke with could clearly describe how they would recognise abuse and the action they would take to ensure actual or potential abuse was reported in a timely way. They confirmed they had received adult safeguarding training. An adult safeguarding policy was in place for the home and the local area safeguarding procedure was also available for staff to access. The local area procedure contact details for reporting a possible safeguarding concern was displayed on the notice board in the staff office.

Effective recruitment processes were in place. We looked at the personnel records for four members of staff recruited in the last year. We could see that all recruitment checks had been carried out to confirm the staff were suitable to work with vulnerable adults. Two references had been obtained for each member of staff.

We asked family members their views about the staffing levels at the home and we consistently heard that the home had sufficient numbers of staff on duty at all times. A family member told us, "They seem to have enough staff. There always seems to be somebody there." Another family said, "I would say there is enough staff. I've not had an occasion where I couldn't find somebody. It's very easy to get hold of staff". Furthermore, a family member told us, "I suppose you always feel you want more staff but there is always staff around and they always provide a service straight away."

We observed plenty of staff on duty during the inspection. We noted that staff were regularly checking on people in the various lounge areas and they responded to requests for support in a timely way. The staff we spoke with said there was sufficient staff on duty to meet the needs of the people living there.

A process was in place for recording, monitoring and analysing incidents. The registered manager reviewed all incident reports and then forwarded them to the quality department for the organisation. Staff told us they received feedback on the outcome of investigations into incidents through shift handovers or the bi-monthly staff meetings.

The care records we looked at showed that a range of risk assessments had been completed and were regularly reviewed depending on people's individual needs. These included a falls risk assessment, lifting and handling assessment, nutritional, skin integrity assessment and a mental health assessment. Care plans had been developed based on the outcome of risk assessments and they provided guidance for staff on how to minimise the risks for each person. Three people had dedicated one-to-one staff support to ensure their safety. We observed that they consistently received this level of support throughout the inspection.

A registered nurse provided us with an overview of how medicines were managed safely within the home. The medication was held in two locked trolleys in a dedicated lockable room. Summary information was displayed in the medication room, including the people with diabetes, people on antibiotics, people in hospital and those prescribed thickener for fluids. A list of staff authorised to administer medicines and their signatures was in place. The medication administration records (MAR) included a picture of each person, any known allergies and any special administration instructions. A medicine risk assessment and support plan was in place for each person. In addition, specific guidance was in place for people who took medicine only when they needed it (often referred to as PRN medicine). Registered nurses had access to an up-to-date nationally recognised medication reference book (referred to as the British National Formula or BNF) to check any queries they may have about a particular medicine.

One person was receiving their medicines covertly. This means that medication is disguised in food or drink so the person is not aware they are receiving it. A mental capacity assessment had been completed to confirm the person lacked capacity to make decisions about their preferred

Good

Is the service safe?

priorities of care and treatment. This assessment was generic in nature and not specific to the decision about giving medicines covertly. We highlighted this to the registered manager at the time of our inspection. The person's GP had provided written agreement for the administration of the medication covertly in the person's best interest. The decision was also discussed with the person's family and the pharmacist.

Medicines requiring cold storage were kept in a dedicated medication fridge. The fridge temperatures were monitored and recorded daily. We noted that some of the recorded temperatures were marginally outside of the required temperatures for storage. This appeared to relate to the temperatures being checked when the fridge was in use and open. However, the registered manager agreed to have the fridge tested to ensure it was working correctly.

Some people were prescribed controlled drugs. These are prescription medicines that have controls in place under the Misuse of Drugs legislation. They were stored correctly in line with the legislation and appropriately signed for once administered to the person. Topical medicines (creams) were stored safely in people's bedrooms.

The registered nurse advised us that a pharmacist called to the home on a regular basis and carried out medication reviews on behalf of the prescribing GP. Medication checks were carried each day by nursing staff at the home. Arrangements were established for the booking in and safe disposal of medication.

We observed the medicines being given to people in the morning and at lunch time. This was done in the dining room by two registered nurses using both trolleys. We noted that the nurses ensured the two trolleys we never left unattended while the medicines were being given out.

We had a look around the home including some bedrooms and observed that the environment was clean and clutter free. Equipment was clean and in good working order. A call-bell system was in place in the bedrooms and it was checked regularly. We spent time with the maintenance person who advised us of the environmental checks they undertook. For example, systems were established for checking the safety of the water, emergency lighting and portable electrical appliances. Service level agreements were in place for heating, lighting, electrical and gas checks.

A fire safety check was conducted each Monday. Fire alarms were tested on a regular basis. A personal emergency evacuation plan (often referred to as a PEEP) was in place for each of the people living at the home. We noted a small number of fire doors were wedged open with various objects. We highlighted this to the registered manager who ensured the objects were removed so the doors could close appropriately. Three bedroom doors, which were fire doors, did not close automatically. The registered manager immediately arranged for the maintenance person to review the doors. The maintenance person confirmed that the closure mechanism on some doors had been adjusted and they were now closing correctly. The matter had also been referred to the fire maintenance team in the organisation.

Good

Is the service effective?

Our findings

Due to needs associated with memory loss, people living at the home were unable to verbally share with us whether they were supported to maintain good health care. Families we spoke with were satisfied that the staff monitored their relative's health care needs and took action when needed. A family member told us, "The chiropodist and optician come here and [relative] has been taken to hospital by a member of staff and I got feedback from staff." Another family member said the staff would send for a doctor if their relative needed it and that the doctor came out when requested.

From our conversations with staff it was clear they had a good knowledge of each person's health care needs. We could see that people had regular and timely input from professionals when they needed it, including the GP, dentist, optician and chiropodist. A record template was in place to record all consultations with health or social care professionals. Some people received specialist health care input when necessary. This included input from the local community mental health team and the speech and language therapy service.

People could choose their own GP. The registered manager said they did encourage families to use the services of a GP who was actively involved with the end-of-life ethos of the home and the pain management programme the home had introduced. The GP routinely spent time at the home twice a week to carry out any required health care reviews.

Nursing staff carried out regular health checks for people, including blood sugar monitoring for people with diabetes, temperature checks, blood pressure monitoring and urinalysis. The registered manager told us that these checks were routinely carried out to check for infections and other potential health concerns.

A member of the inspection team had lunch in the dining room with people living at the home. The dining room was spacious and there was an unhurried atmosphere during the meal. Staff engaged with people whilst they supported them with their meal. Two people said they enjoyed the food. We observed one person pushing their meal away, indicating they were not happy with it. A member of staff immediately provided an alternative meal which the person ate. When people were provided with a drink in the afternoon we noted that they had a choice of snacks, including chopped fresh fruit, crisps, biscuits and chocolate.

Families we spoke with said the food was good and their relatives got sufficient to eat and drink. A family member said, "He seems to enjoy his food. He ate his tea himself and the staff are always bringing him drinks." Another family member said about their relative, "He has lost a lot of weight and the staff keep going to him with [fortified drinks]. They sit with him and try to encourage him. They know what he is eating and drinking." Regarding choice, another family member said, "The staff make him whatever he wants." A family member told us their relative had a blended diet and said, "He enjoys his food. It's a pureed diet and it's all presented separately."

We spent time with the chef who confirmed people could have what they wished for their meals. They told us people got fresh fruit, vegetables and meat each day. Butter, full fat milk and ice cream was used to increase calorie intake. The chef said they had advised the catering team, "Not to give the residents anything you would not eat yourself."

The registered manager told us people were weighed each week. Anybody who had lost over 2kg in a month was referred to the GP or the dietician for an assessment. We could see from the care records that each person's weight was monitored as the registered manager described.

We looked to see if the service was working within the legal framework of the Mental Capacity Act (2005). This is legislation to protect and empower people who may not be able to make their own decisions, particularly about their health care, welfare or finances. We could see from the care records that advance care planning (ACP) was in place for people living at the home. ACP is a structured discussion with people and/or their families and carers about their wishes for the future, particularly in relation to end-of-life treatment and care. We observed that the ACPs were signed by the GP and we could see the plan had been discussed with the family if their relative lacked capacity.

Mental capacity assessments had been completed as part of the ACP process. We noted the mental capacity assessments were standardised and the decisions listed were the same for each person. These were in accordance with the North West End of Life Model of Care and included; living in the home, preferred priorities of care and ACP

decisions. 'Preferred priorities of care' is a nationally recognised approach for people to express their end-of-life wishes. We discussed with the registered manager that the 'preferred priorities of care' may not cover some specific decisions, such as the administration of covert medicines. The registered manager agreed to explore this further.

The registered manager confirmed that the staff team had received training in the Mental Capacity Act (2005). The staff we spoke with confirmed they had received this training and they demonstrated a good understanding of The Act. Staff told us they did not use restraint but were trained in breakaway techniques purely so they could free themselves safely if grabbed and held by a person.

The registered manager advised us that applications in relation to Deprivation of Liberty Safeguards (DoLS) had been submitted to the Local Authority for each of the people living at the home. DoLS is part of the Mental Capacity Act (2005) and aims to ensure people in care homes and hospitals are looked after in a way that does not inappropriately restrict their freedom unless it is in their best interests. The registered manager confirmed that some people had been assessed by the Local Authority and had a standard authorisation in place. The remaining people were awaiting an assessment.

The staff we spoke with consistently told us they were up-to-date with their annual appraisal and said they received regular supervision. A supervision schedule was displayed on the notice board in the office. Staff told us they were up-to-date with the training and refresher training they were required by the provider to complete.

The families we spoke with said staff had the necessary skills to provide effective care. A family member told us, "I think the staff are very professional." Staff also told us the quality of training they received was good and they said they received regular refresher training. A member of staff said, "The training is amazing here. The manager makes sure you are trained right." The registered manager told us they held a meeting with the registered nurses each month and checked whether appraisals and supervision were up-to-date for the care staff team. The registered manager provided clinical supervision for the nurses.

We spoke with a recently recruited member of staff who described a thorough induction involving a shadowing a more experienced member of staff. They were provided with time to familiarise themselves with the home's procedures and people's care needs. The new member of staff had completed the Cavendish Care certificate induction course which the provider had introduced for all newly recruited staff. This new care certificate has been introduced nationally to ensure care workers are consistently prepared for their role through learning outcomes, competences and standards of care. They complete the induction course prior to starting the job.

We had a look around the building to see how well it had been adapted to support the needs of people living with dementia. In accordance with national guidance on dementia friendly environments, we observed that the internal environment was spacious and airy. The décor was bright with minimal patterning and was clutter free. There were meaningful reminiscence displays and wall art located throughout the building, such as memory boxes and a seaside display. Flooring was un-patterned to support people to mobilise safely. There were a number of small seating areas located throughout the building. This layout meant that people who liked to walk about could do so safely and have access to a seating area if they needed to rest.

Contrasting colour and signage had not been effectively used to promote people's orientation and independence in locating rooms. For example, bedroom doors and hand rails in the corridors were all in similar colours. The registered manager said they would look into this. Bedrooms were personalised to each person's preferred taste. A picture of the person was displayed on their bedroom door to assist with the person locating their room. Some of the pictures were related to the person's past as often people with dementia recognise themselves more readily from their younger years. People had access from patio doors to well maintained and secure garden spaces. Different coloured crockery was used for each mealtime to encourage people to recognise which meal it was.

Outstanding ☆

Is the service caring?

Our findings

We asked people living at the home if staff treated them with dignity and respect. They all responded with "Yes". Because few people were able to verbally share their views with us, we spent periods of time throughout the day watching and listening to how staff interacted with people. Staff approached people with a smile and spoke with them in gentle tones, and people responded positively to this approach. Staff were patient, pleasant and kind in the way they interacted with people. We observed people were comfortable around the staff and at ease approaching them. We noted staff were very attentive and we observed staff sitting with different people during the day and just simply having a chat with them. Personal care activities were carried out in a discreet way.

Families we spoke with were equally happy with the person-centred care, attentiveness of staff and the way staff engaged with their relatives. A family member said, "From what I see the staff are very friendly. I'm impressed." Another family told us, "I think the staff look after [relative] as an individual and give him the care he requires." We were informed by another family member, "I think it is excellent here. The home runs smoothly. The staff are excellent and caring."

We asked families what they liked best about the home. We received a wide variety of responses, including positive feedback about the care and the attitude of staff. A family member said they liked, "The reassurance my relative is being looked after in safe hands day and night." Another family said, "It's the caring staff they have. They are incredible. I admire the staff so much for what they do."

Families told us they could visit their relative whenever they wished. A family member said, "We just come whenever. The staff make you very welcome." Another family told us, "We do come at different times. There's no restriction on numbers [of visitors]." Families told us they could spend time with their relative in one of the shared areas, the quiet lounge or their relative's bedroom. We observed a steady stream of visitors throughout the inspection. The staff knew visitors by name and greeted them in a friendly and welcoming way.

We heard from families that staff communicated well with them and in a timely way about their relative's changing needs. They found this level of communication reassuring. A family member told us, "I know exactly what is happening. When the staff can't get hold of me they phone my son." Another family said, "If the doctor has been called or if he has had a fall the staff contact me." We observed notice boards in the home that included information for families, such as relative meeting dates and planned trips out.

The staff we spoke with had good knowledge of each person's background, needs and preferences. They spoke about people with warmth and demonstrated a positive regard for the people living at the home. A member of staff said to us, "I love looking through people's photograph albums with them. It's amazing the things they can remember from years ago but not now. The more I go on dementia training the more I understand the people here." All the staff we spoke with had received training in the care of people living with dementia.

The registered manager explained that the home provided end-of-life care. The staff team had completed the foundations in palliative care training programme. The home was assessed and accredited for the Gold Standards Framework (GSF) in March 2014. The GSF is an evidence-based approach in end-of-life care and the national GSF centre provides training for all GSF programmes. Green Heys was the first care home in Sefton to achieve this care home quality award. The registered manager explained that the home had good relationships and worked closely with the local palliative care team, the GP and other community health care providers.

The home used the North West End of Life Care Model to assess where each person was at in terms of the progress of their dementia. Staff advised us that each stage of the model highlighted the care and support that was required. The registered manager informed us they held a meeting with the registered nurses each month and each person's care and support was discussed and revised in accordance with the model. Each person admitted to the home was referred for a continuing healthcare funding assessment. This was in accordance with the North West End of Life Care Model.

Based on published research related to treating pain in order to reduce behavioural disturbances in people living with dementia, the registered manager explained the nursing team had worked closely with the GP and community pharmacist to develop a systematic approach to the management of pain people may be experiencing.

Outstanding ☆

Is the service caring?

The home used the Abbey Pain Scale, a recognised assessment measure of pain in people living with dementia who cannot verbalise if they are in pain. A 'Pain ladder' was used to rate each person's level of pain in terms of severity.

As a result of this detailed pain assessment and treatment appropriate to the each person's level of pain, the registered manager told us there had been a reduction of 93% in the incident rate of behaviours that challenge. We were informed that people's diet and wellbeing improved once their pain was treated. Furthermore, the registered manager advised us that the use of bedrails reduced considerably once people were more settled due to effective pain management.

A member of staff said to us, "Working in line with the GSF changed the way we did everything." They said staff work closely with the GP, particularly with assessing and reassessing people's pain level. The member of staff said, "Through the use of regular analgesia [pain relief] hardly anyone is on medication [to manage agitation]. Bed rails and lap straps are no longer needed."

We looked at a care record for a person who was assessed as being at an advanced stage of dementia in accordance with the North West End of Life Care Model. The person also experienced a lot of pain. We could see that detailed assessments were place, including a pain assessment. Care plans had been developed based on the outcomes of the assessments. We could see from the records that the person's family had been involved in the care planning process. They contributed along with the GP to the Advanced Care Plan (ACP) for their relative. The person's wishes regarding resuscitation were considered as part of the ACP process and a 'Do not attempt resuscitation' authorisation was in place. It had been signed by the GP and family. ACPs were regularly reviewed with the family to ensure they remained current and reflective of the person's wishes.

Families informed they had been actively involved in developing the care plans for their relatives. A family member told us, "I had to sit down and go through a big booklet. The staff sat down with my son and daughter and gave them the opportunity to ask questions." Another family member said, "The day he came in we sat for about an hour going through the care plan." Families said they were also involved in care plan reviews. A family member said to us, ""There has been a review of her care plan and we have updated it."

A quiet room was available and the registered manager advised us that families could use this room at any time and could use it to sleep in if they needed to spend the night at the home with their relative. Vending machines for drinks and snacks were available for people and visitors to use.

The registered manager told us the home had access to an advocacy service if anyone living there needed to use it. Families we spoke with were aware that the home could access an advocacy service if they needed it.

Good

Is the service responsive?

Our findings

Families we spoke with were pleased their relatives were treated as individuals and care was tailored to their specific needs. We asked families how staff responded to their relative's particular needs. A family member told us the staff always put Abba on in the bedroom as they know their relative liked this music. The family member also said, "They leave his curtains open and light on because he prefers that."

People's care records informed us they had a detailed assessment prior to moving into the home. The registered manager said this was important to ensure the home could meet their needs, refer to the appropriate community services and to ensure the home was the right living environment for the person to live in. We could see from the records that any new or progressing health care needs people presented with were responded to in a timely way.

Each of the care records we looked at contained a 'One page profile' about the person. It included information about what was important to the person, what people liked and admired about the person and how best to support the person. New staff told us they found this profile useful in order to ensure they were supporting the person in a way the person preferred. Furthermore, the bedrooms we looked at included a visual display of speech bubbles with a brief summary of the person's preferences, such as the way they liked to take their tea and the time they liked to get up in the morning.

Each of the care staff was a keyworker for a small group of people. They explained the role involved making sure the people they were responsible for had enough clothing and toiletries, and that their personal care and social needs were being met in a way they preferred.

We noticed a wide variety of easy chairs and specialist seating was available. The registered manager advised us that people were assessed to ensure their seating was specific to their needs and comfort. Some of the seating had wheels which meant the number of transfers people had to make, particularly people who were frail, was reduced considerably.

An activities coordinator worked full time at the home over a seven day period. Care staff also supported people with activities. Families were very pleased with the level of activity both in and outside of the home. They told us about weekly trips out in the minibus to local places of interest. Families said external entertainers came to the home to facilitate activities. People participated in group and/or individual activities depending on their preference. A family member said to us, "They have people coming in. I'll take him out in the wheelchair, as do the staff. He likes to go out." Another family said, "He has been out to the garden centre for tea and cake. He has never been a group person so the staff spend time with him. It was good they recognised this so they talk to him about family and look at old photographs." Another family member told us, "Sometimes I help the activities coordinator. They have a silk parachute and play with a ball. There is a music quiz and they always have singers in. The people really enjoy that."

Families we spoke with were aware about how to make a complaint about the service. A complaints procedure was in place and this was displayed in the foyer. The registered manager advised us that one formal complaint had been received in the last 12 months. This had been appropriately addressed by the registered manager and the complainant informed of the outcome. A change in practice had been instigated as a result of the investigation, which showed the registered manager had recognised that improvements could be made from the outcome.

'Resident and relative' meetings were held on a bi-monthly basis at the home. The meeting minutes informed us that topics, such as the décor, menu and activities were discussed at each meeting. The chef told us they attended the meeting and took the opportunity to ask people living at the home and families their views of the food. Some family members we spoke with said they had attended some of the meetings. A family member said, "I have been to one resident's meeting. I have not had any feedback. It could be up on the notice board but I have not noticed." Another family told us, "There is generally feedback from the meetings on the board." The registered manager confirmed that the minutes were displayed on the notice board following each meeting. A family member also told us, "I think there is a suggestion box. If I had any suggestions I would air them."

The registered manager advised us that formal feedback was sought from people living at the home and their families every six months. We could see that completed questionnaires had been recently returned but these had not yet been analysed to identify any emerging themes or

Good

Is the service responsive?

patterns. The registered manager advised that any emerging trends or patterns from the feedback were discussed at the bi-monthly heads of department meetings. We were provided with recent minutes of these meetings.

Good

Is the service well-led?

Our findings

The registered manager had been registered with the Care Quality Commission on 1 October 2010. The registered manager was supported by two assistant managers and a team of registered nurses, care and ancillary staff. Our records informed us that the registered manager appropriately notified CQC of events and incidents in accordance with the regulations.

We asked families their views of the leadership and management of the home. Families were unanimous in their view that the home was very well led and managed. With reference to the registered manager, a family member said, "I am grateful she came to see us. She is very compassionate. I'll always be grateful she said she would take [relative]."

We asked families if the service could be improved in any way. Besides a person suggesting a bigger car park, families could not think of any improvements. A family member said, "I don't think it needs improving. I'm happy with the way everything is."

The staff we spoke with were equally positive about the leadership and management of the home. It was clear from our discussions and observations that they felt very well supported by management and that management led by example. Staff told us it was a good place to work as the team worked well together and supported each other. They told us an employee of the month scheme was in place. A member of staff said, "The manager is very supportive. She leads by example and empowers you so you progress. She trusts your decisions and works with you." Another member of staff told us, "The manager is one of the best and she listens to you. She deals with things right away and knows all the residents by name."

We asked staff their views on what the home did well. All suggested the care was good and personalised. A member of staff said, "The person-centred care is very good. Everyone is treated as an individual." Regarding further improvements there were few suggestions. One member of staff said they would like to have a small kitchen "where people could be supported to make things".

Staff told us an open and transparent culture was promoted within the home. They said they were aware of the whistle blowing process and would not hesitate to report any concerns or poor practice. They were confident the registered manager would be supportive and protective of them if they raised concerns. A member of staff said, "I'd like to think if I saw anything untoward I'd go straight to the manager and she would see to it straight away."

We asked the registered manager about the overarching quality monitoring framework for the service. The home was part of the CQUIN scheme. This is a national scheme which stands for Commissioning for Quality and Innovation. It is designed to focus on quality, innovation and seeks to improve the quality of care. The registered manager collated information each month and forwarded it to a central data base. It meant the manager was routinely monitoring, analysing and reporting on quality and risk issues each month. We could see from the CQUIN reports that the areas reported included: the number of DoLS assessments completed; number of safeguarding referrals made; numbers of complaints received and the number of falls.

In addition, the registered manager completed a clinical governance report each month that was forwarded the organisation's quality department. We looked at the report for March 2015 and noted that it reported on: unplanned hospital admissions; deaths; weight loss of people living at the home and the action taken; pressure ulcers and the action taken and people at risk of falling out of bed.

A senior manager in the organisation carried out a service quality audit on a quarterly basis. The registered manager advised that this was a detailed audit that took into consideration all elements of the service, including checking 10% care records, checking staff records and seeking the views of people living there and their families. We looked at the last audit and noted an action plan had been produced and the actions had since been addressed. The outcome of these quality audit processes coupled with other sources of information informed the corporate level risk rating process (referred to as 'Q Pulse'). Ratings were based on the traffic light system and Green Heys was rated 'green', which meant there were no concerns about the service.

The registered manager advised us they had monthly supervision with their line manager. They also attended monthly meetings with other registered managers within the provider group.

Good

Is the service well-led?

Each person's risk assessment and care were regularly reviewed and we could see that the reviews were in-depth and action taken where necessary, such as referral to a health professional. The registered manager held a clinical supervisory meeting with the nurses once a month to review people's care including their advanced care plan.

We found staff consistently very person-centred in the way they supported people but we did not find the care plans to be as person-centred as they could be. The reason for this was that standardised care plan templates were used that included the pre-populated need and actions to take.

Although some care plans had been modified to reflect individual need, this approach to developing care plans is not in keeping with the spirit of person-centred planning. The registered manager agreed to look into this further.

Staff told us communication was excellent at the home. They said they received good handover when they came on duty. A meeting structure was in place for the sharing of information and the outcomes of investigations. This included bi-monthly meetings with the heads of department and a bi-month full staff team meeting.