Care Quality Commission

Caring Homes Healthcare Group Limited

Heffle Court

Inspection report

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Ratings

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

Overall summary

This inspection took place on 30 March 2015 and was unannounced.

Heffle Court is a purpose-built care home offering residential and nursing care for older people. There is a designated floor in the service for people who need nursing care. Nursing and residential care is provided for up to 41 people living with Alzheimer's disease and other progressive dementias. This is for long term care, or a period of short term or respite care. There were 36 people living in the service on the day of our inspection.

During the inspection the registered manager was on annual leave, but came in to be part of the inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

There were not always sufficient numbers of suitable staff to keep people safe and meet their care and support needs. People's individual care and support needs were

Summary of findings

assessed before they moved into the service. However, we found for one person their care needs had not been fully identified to ensure all their care needs were met. Care and support plans provided guidance on the personalised care to be provided and based on the identified needs of each individual. However, although care staff were aware of the care to be provided staffing levels had not always ensured that personalised care could be delivered. People's care and support plans and risk assessments were detailed and reviewed regularly. However, some risk assessments on the nursing floor lacked guidance in meeting specific health needs such as epilepsy.

People were able to join in a range of activities in the service to help them with their social care needs. However, when the activities co-ordinator was not on duty care staff had limited time to run activities in their absence. This meant there were periods of time when people were not able to join in activities.

People were supported to take their medicines safely. However, where medicines were given covertly current guidance had not all been followed to fully protect people.

There was a maintenance programme in place for the repair and renewal. The environment was spacious which allowed people to move around freely without risk of harm. However, areas were identified in need of repair or renewal.

Whilst there were quality assurance systems in place they had not identified that people's safety was potentially at risk from inadequate staffing levels that impacted on care delivery and raised potential risks to people's safety. This meant that the people had not been protected against unsafe care and treatment by the quality assurance systems in place.

Where people were unable to make decisions for themselves the service had considered the person's capacity under the Mental Capacity Act 2005, and had taken appropriate action to arrange meetings to make a decision within their best interests.

People were treated with respect and dignity by the staff. They were spoken with and supported in a sensitive, respectful and professional manner.

People and their visitors told us they knew who they could talk with if they had any concerns. They felt it was somewhere where they could raise concerns and they would be listened to. The registered manager also told us that they operated an 'open door policy' so people living in the service, staff and visitors could discuss any issues they may have.

Staff told us they were supported to develop their skills and knowledge by receiving training which helped them to carry out their roles and responsibilities effectively. Training records were kept up-to-date, plans were in place to promote good practice and develop the knowledge and skills of staff.

People's individual's dietary requirements formed part of their pre-admission assessment and people were regularly consulted about their food preferences. People had access to health care professionals. All appointments with, or visits by, health care professionals were recorded in individual care plans. Healthcare professionals, including speech and language therapists had been consulted with as required.

Staff told us that communication throughout the service was good and included comprehensive handovers at the beginning of each shift and regular staff meetings. They confirmed that they felt valued and supported by the managers, who they described as very approachable.

People were asked to complete an annual satisfaction questionnaire, and had the opportunity to attend residents meetings. The registered manager told us that senior staff carried out a range of internal audits, and records confirmed this.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which correspond to breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have asked the provider to take at the back 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 consistently safe. Staffing levels did not ensure that people living with dementia received all the care and support they required at the times they needed.

Medicines were stored appropriately and there were systems in place to manage medicine safely. However, where medicines were being given covertly this practice did not fully follow current guidance to fully protect people.

People had individual assessments of potential risks to their health and welfare, which had been regularly reviewed. However, some care plans on the nursing floor lacked guidance in meeting specific health needs such as epilepsy to fully protect people.

There was a maintenance programme in place. However, there were areas in the service in need of repair.

Is the service effective?

Good

The service was effective. Staff had a good understanding of peoples care and support needs.

People were supported by staff that had the necessary skills and knowledge. Staff had up-to-date training and regular supervision and appraisal to ensure they could meet the needs of people in the service.

Staff were aware of the Mental Capacity Act 2005 and how to involve appropriate people in the decision making process if someone lacked capacity to make a decision.

People's nutritional needs were assessed and recorded.

Is the service caring?

Good

The service was caring. Care staff involved and treated people with compassion, kindness, and respect.

People and their visitors were pleased with the care and support they received. They felt their individual needs were met and understood by staff.

People and their visitors told us care staff provided care that ensured their privacy and dignity was respected.

Is the service responsive?

Requires Improvement

The service was not consistently responsive. Staffing levels in place had not ensured that people had always received personalised care or opportunities to join in social activities when they need to.

The views of people, and visitors were welcomed and informed changes and improvements to service provision.

Summary of findings

People were comfortable talking with the staff, and visitors told us they knew how to make a complaint if necessary.

Is the service well-led?

Requires Improvement 

The service was not consistently well led. Whilst there were quality assurance systems in place, however they had not identified that people's safety was potentially at risk from inadequate staffing levels that impacted on care delivery and raised potential risks to people's safety.

There was a registered manager in post, who was supported by a team of senior staff. The leadership and management promoted a caring and inclusive culture.

There was a clear vision and values for the service, which staff promoted.

Heffle Court

Detailed findings

Background to this inspection

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

This inspection took place on 30 March 2015 and was unannounced.

The inspection team consisted of two inspectors and an expert-by-experience who had experience of older people's dementia care services. 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 the inspection, we reviewed information we held about the service. This included previous inspection reports, and any notifications, (A notification is information about important events which the service is required to send us by law) and complaints we have received. Before the inspection the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. This enabled us to ensure we were addressing any potential areas of concern. We telephoned the local authority commissioning team, who have responsibility for monitoring the quality and safety of the service provided to local authority funded people. Following our visit, we telephoned a social care professional to ask them about their experiences of the service provided.

We used a number of different methods to help us understand the views and experiences of people, as they not all were able to tell us about their experiences due to their living with dementia. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk withus. We used this tool to observe lunchtime on the residential unit. We spoke with four people living in the service, seven visitors who were friends or relatives and a visiting community nurse. We spoke with the regional manager, the registered manager, the deputy manager, a senior care worker and four care workers, a laundry assistant and a registered general nurse (RGN). We observed care and support provided in the communal areas, and the mealtime experience over lunchtime.

We observed medicines being given to people and looked around the service including the communal areas, people's bedrooms, and the garden. As part of our inspection we looked in detail at the care provided to eight people, and we reviewed their care and support plans. We looked at menus and records of meals provided, medication administration records, the compliments and complaints log, incident and accidents records, records for the maintenance and testing of the building and equipment, policies and procedures, meeting minutes, staff training records and two staff recruitment records. We also looked at the service's own improvement plan and quality assurance audits.

Requires Improvement

Is the service safe?

Our findings

Visitors told us they felt people were happy and were well treated in Heffle Court. One visitor told us when asked if people were safe, "I've got no qualms about that (safety)." However, we found areas of practice that required improvement.

Feedback from visitors was varied as to if there was sufficient staff on duty in the service. One visitor told us, 'We're impressed with the number of staff." But another visitor described Heffle Court as, "Busy and chaotic." Another visitor told us, "There's not enough to do – very little stimulation or people to talk to. The carers don't have the time."

We looked at the skill mix, staff experience, numbers of staff and the deployment of staff in the service. We found the staffing levels were not sufficient to provide the level of care and supervision to ensure their safety required by people living at Heffle Court. On the day of the inspection the numbers of care staff actually on duty was one less than planned and recorded on the staff rota. A replacement member of care staff or agency care staff had not been requested to provide cover. We were told a replacement care staff had been forgotten to be requested. This led to care staff working on the residential unit leaving to help care staff on the nursing unit when they needed assistance. This then impacted on the care and support care staff were able to provide to people on the residential unit during the day and especially at lunch time.

One of the inspectors undertook a SOFI observation and the expert-by-experience also sat and observed the lunchtime experience in the residential unit. Care staff on the residential unit were very busy during lunch time, and were not able to adequately monitor if people had had sufficient food and fluids. Care staff were called away to respond to competing demands from individual people, which led to a handing over of tasks between care staff of tasks to be completed. We saw one person trying to eat the lunch of another person. Another person was pouring water on the floor. This led to a lack of continuity with more than one care staff assisting individual people to eat their meal as they were called away to support people. It would not have been possible to accurately assess or record how much people had eaten or had to drink.

Care staff could not adequately supervise people on the residential unit who were mobile and had access to a set of stairs between the lounge and a number of bedrooms. Two people tried to help each other walk up the stairs independently. Although staff told us these people could use these stairs independently they became stuck halfway up the stairs unable to get further up or go back down. As a result we intervened as one person became unsteady and we helped them back down the stairs. Care staff were not available to supervise and provide support, and potentially placed people at risk. Care staff were not able to appropriately supervise people who were unable able to move around independently on the nursing unit. One person was observed on their own in the lounge area for long periods of time, and were not being monitored to ensure their safety despite their care plan detailing they were at risk from slipping out of their chair. Some people on the nursing unit did not receive their personal care until lunch time as there were not enough staff on duty to support them. One person had not received a change of position for five hours. Their care plan detailed they should be turned every two hours to help protect their skin from pressure damage. Throughout the day we saw instances where care staff were stretched to provide the level of supervision and care required for the people they cared for. The number of care staff on duty impacted on the care delivery and safety of people throughout the service on the day of the inspection.

Staff feedback was varied when asked if there was enough staff on duty to provide the care to people. They told us there was not always enough staff on duty to provide the care they needed. For example, one staff member told us more staff were needed because, "They want more time with you. More people could go outside." Another care staff told us, "It's so busy. You are always on catch up as residents come first. I think we need more staff particularly at busy times." Another care staff told us it had been a very busy day but, "Some days go really smoothly."

Ancillary staff covered catering, domestic, maintenance and clerical duties in the service. Although visitors told us they were generally happy with the cleanliness of the service, the cleanliness of the service on the day of the inspection was impacted on by the fact there was only one cleaner on duty. This was due to the second cleaner being on annual leave. Carpets were unclean and stained and

Requires Improvement

Is the service safe?

chairs were stained and covered in dried food debris. One member of staff told us, "It's a big place, one cleaner on –it's a struggle." This impacted on the cleanliness of the environment.

The staffing levels provided had not ensured that people received all the care and support that they needed. This was a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 now Regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People on the residential unit had individual assessments of potential risks to their health and welfare and these were reviewed regularly. Where risks were identified, staff were given clear guidance about how these should be managed. Staff also told us if they noticed changes in people's care needs, they would report these to one of the managers and a risk assessment would be reviewed or completed. However, some assessments on the nursing unit lacked guidance in meeting specific health needs for example such as epilepsy. One person who lived with epilepsy had a very brief care plan in place for this specific need and how to minimise the risk. There was no information of what could trigger a seizure, telling signs of imminent seizure or how staff should manage a seizure to ensure the person's safety and comfort. There was no mention of how the person might feel following a seizure and of how staff were to reassure and assist the person. There was evidence of consultation with the speech and language team (SALT) within peoples care and support plans. For one person there were two care plans that gave differing advice and guidance on management. We were subsequently informed this was due to the care plan being in the process of being updated and that staff had been informed of this. However, there was a potential risk that the person would receive the incorrect diet they needed. Mobility care plans were not all accurate and provided contradictory information. For example, one person's care plan stated that the person was not mobile, but staff informed us the person was mobile. There was no guidance as to the support needed for this person to mobilise to protect them. Staff told us the person needed supervision and support. For another person staff had identified the risk the person slipping whilst sitting in a chair and needed the guidance of an occupational therapist. A request had not been made and there was no risk assessment or guidance in place to reduce the risk of the person slipping. People identified at risk of developing pressure ulcers had air mattresses to minimise the risk. These had been regularly checked and settings recorded to ensure they were maintained to meet people's individual assessed needs.

People had not been protected where risks had been identified but detailed guidance had not been provided for staff to follow to minimise the risks identified. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 now Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We observed one person who had their medicines covertly administered. Staff had identified that this person required their medicine crushed and in food to disguise the taste of medicine. This was to ensure that the medicine was not refused, as the person needed the medicine to sustain their health. This had been discussed with the person's doctor and documented in the Medication Administration Record (MAR). However, this had not been updated to follow current guidance from NICE (The National Institute for Health and Care excellence) to fully protect people when administering medicines covertly.

Medicines were supplied monthly in weekly blister packs. We observed the lunch time medicines being given to people. On the nursing unit, we observed the registered nurse administer the medicines and we saw they were checked and double checked at each step of the administration process. The staff also checked with each person that they wanted to receive the medicines and asked if they had any pain or discomfort. We looked at a sample of medicine administration records on both the units and found that they were completed correctly, with no gaps identified. Photographs of people who had medicines administered were not all in place or were in need of updating. Agency staff were used to cover staff absences and administer medicines. The provision of a current photograph of people was used as part of the checks to ensure medicines were administered to the correct person. The lack of a vital check of a current photograph did not fully protect people.

There were guidelines for the administration of medicines required as needed (PRN). Staff knew when PRN medicines should be given and why. Staff were able to explain the safe procedures that they followed for the receipt, storage, administration, recording and disposal of medicines.

Requires Improvement

Is the service safe?

We checked that medicines were ordered appropriately and staff confirmed this was done on a 28 day cycle. Medicines which were out of date or no longer needed were disposed of appropriately. The storage of the medicines were safe and appropriate and records of temperatures of medicine storage rooms and medicine fridges were recorded daily and within the recommended temperatures.

There was a maintenance programme in place for the repair and renewal to protect people. However, we saw there were areas in need of repair to ensure the building remained safe for people to use. For example a number of the wall tiles had come off the wall in one bathroom. The rubber carpet edging in the downstairs lounge area had come away from the carpet in two areas. Staff told us about the regular checks and audits which had been completed in relation to fire, health and safety and infection control. Records confirmed these checks had been completed. There was no record of any checks of the smoke detecting equipment in between the maintenance visits made by the external contractor. The registered manager has subsequently told us the fire detection system was self checking and immediately alerts staff of any faults with all smoke detecting equipment throughout the building. Contingency plans were in place to respond to any emergencies, flood or fire. Staff told us they had completed health and safety training. There was an emergency on call rota of senior staff available for help and support. Appropriate checks were completed to ensure staff and equipment were safe to support people who lived at the service.

The provider had a number of policies and procedures to ensure care staff had guidance about how to respect people's rights and keep them safe from harm. These had been reviewed to ensure current guidance and advice had been considered. This included clear systems on protecting people from abuse. The registered manager told us they were aware of and followed the local multi-agency policies and procedures for the protection of adults. They had notified the Commission when safeguarding issues had arisen at the service in line with her registration requirements, and therefore we could monitor that all appropriate action had been taken to safeguard people from harm. Care staff told us they were aware of these policies and procedures and knew where they could read the safeguarding procedures. We talked with care staff about how they would raise concerns of any risks to people and poor practice in the service. They had received safeguarding training and were clear about their role and responsibilities and how to identify, prevent and report abuse.

There was a whistle blowing policy in place. Whistle blowing is where a member of staff can report concerns to a senior manager in the organisation, or directly to external organisations. The care staff we spoke with had a clear understanding of their responsibility around reporting poor practice, for example where abuse was suspected. They also knew about the service's whistle blowing process and that they could contact senior managers or outside agencies if they had any concerns.

People were cared for by staff who had been recruited through a safe recruitment procedure. Where staff had applied to work at Heffle Court they had completed an application form and attended an interview. Each member of staff had undergone a criminal records check and had two written reference requested. This meant that all the information required had been available for a decision to be made as to the suitability of a person to work with adults.

Good

Is the service effective?

Our findings

People and the visitors told us they felt the care was good. People were living with dementia and were not all aware of their care and support plans, but where possible they were involved in decisions about their care and were kept informed of any changes to their care and support plans.

There were clear policies around the Mental Capacity Act 2005 (MCA.) The MCA is legislation which provides a legal framework for acting and making decisions on behalf of adults who lack the capacity to make decisions for them. DoLS are the process to follow if a person has to be deprived of their liberty in order for them to receive the care and treatment they need. The registered manager told us that if they had any concerns regarding a person's ability to make a decision they worked with the health and social care professionals to ensure appropriate capacity assessments were undertaken. Care staff told us they had completed or were due to complete this training and all had a good understanding of the need for people to consent to any care or treatment to be provided. One member of staff told us, "We don't force people." They described how some people needed more time to wake up in the morning. For one person they told us when they did not want any care or support in the morning, "I leave and make her a cup of tea and then go back."

CQC is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS). DoLS are the process to follow if a person has to be deprived of their liberty in order for them to receive the care and treatment they need. The registered manager told us they were aware how to make an application, and about the DoLS applications that had already been made for which staff were awaiting confirmation from the Local Authority if these applications had been agreed. Care staff told us they had completed or were due to complete this training and all had a good understanding of what this meant for people to have a DoLS application agreed, they were clear who had been put forward for a DoLS application, and any actions they had to follow to support people where an application had been agreed.

People were supported by care staff that had the knowledge and skill to carry out their roles. The registered manager told us all care staff completed an induction which met the common induction standards before they supported people. This was to ensure that new care staff had the skills to provide the care to people. There was a period of shadowing a more experienced staff member before new care staff started to undertake care on their own. The length of time a new care staff member shadowed was based on their previous experience, whether they felt they were ready, and a review of their performance. The new care staff confirmed this, and told us they had received the information and support they needed to start working on their own. This had ensured that care staff had the information they needed to support people living in the service.

Staff received training to ensure they had the knowledge and skills to meet the care needs of people living in the service. Care staff received training that was specific to the needs of people using the service, which included training in moving and handling, medicines, first aid, safeguarding, health and safety, food hygiene, equality and diversity, and infection control. Care staff spoke of training they had attended to help them understand and support people living with dementia. They told us this had given them a greater insight into how people who were living with dementia felt and could react. One care staff told us, "The training and support is very good here. We have had good training on how you feel if you have dementia." Another care staff told us they had received this training and, "It's common sense. It helps with awareness and how to communicate."

Staff told us that the team worked well together and that communication was good. One member of staff told us, "The staff are lovely and caring. Even when it gets difficult people are calm and work through it." They told us they were involved with any review of the care and support plans. They used shift handovers, and a communications book to share and update themselves of any changes in people's care. Staff told us they felt well supported and had received regular supervision and appraisal from their manager. This was through one-to-one meetings. These processes gave staff an opportunity to discuss their performance and for the manager to identify any further training they were due to attend. Senior staff told us they used care staff supervision and observations to monitor the care provided. Periodic staff meetings had been regularly held.

People's physical and general health needs were monitored by staff and advice was sought promptly for any health care concerns. Care plans contained

Good

Is the service effective?

multi-disciplinary notes which recorded when healthcare professionals visited such as GPs, social workers, nurses or dieticians and when referrals had been made. Care staff told us that they knew the people well and if they found a person was poorly they should report this to the manager. People were supported to maintain good health and received ongoing healthcare support. Visitors told us they were kept in touch with any changes in people's health and care needs. One visitor told us, "I get frequent phone calls to say if my relative has had a fall."

People's weights were monitored and there were clear procedures in place regarding the actions to be taken if there were concerns about a person's weight, for example if there had been a decrease in weight which could lead to more frequent monitoring of a person's weight. Staff told us they were aware of where the care and support plans were to update themselves with any changes to each person's care. However, they primarily used the shift handovers, and a communications book to share and update themselves of any changes in people's care. Care staff were seen to updating people's care and support plans during the day to ensure that all the staff on duty were aware of the care that had been given. Care staff demonstrated a good knowledge of people and their individual care needs and likes and dislikes.

People's nutritional needs were assessed and recorded, and people's likes and dislikes had been discussed as part of the admissions process. Records were accurately maintained to detail what people ate to inform staff if people had had adequate food and fluid during the day. Some people had food and fluid intake charts. They relied on care staff to ensure they had enough to eat and drink throughout the day. We found that these had been accurately completed, and had been totalled at the end of the day. This was to ensure care staff had a clear and full picture of if people had received adequate fluids during the day to maintain their wellbeing. People's weights were monitored regularly with people's permission and there were clear procedures in place regarding the actions to be taken if there were concerns about a person's weight. For example where a person had lost weight more frequent checks of their weight had been carried out and their diet reviewed and a fortified diet considered.

There was a four week, seasonally changed menu, which showed choices were available at each meal and further alternatives if needed. The menu was displayed in each lounge area and showed people the options available that day. There was a pictorial menu to help people make their choice from the options available. Some people had specific dietary requirements either related to their health needs or their preference and these were detailed in their care plans. Drinks and snacks were available for people to have throughout the day and night. There was a kitchenette area for people and their visitors to make drinks and snacks. Care staff were regularly checking with people if they would like a drink or a snack, and discussing their choices with them. The time for people to have breakfast was variable to suit the different times that people liked to get up in the morning. We saw people eating their breakfast during the morning after they had been assisted to get up. Lunch was between 12.30 -2pm again to suit the individual preference of people.

Good

Is the service caring?

Our findings

People and their visitors told us people were treated with kindness and compassion in their day-to-day care. They stated they were satisfied with the care and support people received. They were happy and they liked the staff. Visitors commented when asked if staff were caring, "They are kind," "They are kind – I haven't seen anything unkind," "The carers are kind and the head of care is very good," and "The staff are all very good – friendly and nice." One staff member told us, "Residents are a priority here."

The service provided care and support to people living with dementia. Due to the communication needs of the people living with dementia we were not able to get detailed responses to our questions. We spent time in the communal areas with people and staff. People were comfortable with staff and frequently engaged in friendly conversation. We observed even though staff were rushed they showed patience, understanding and treated people with kindness whilst supporting them to eat their meal. A safe, well designed and caring living space is a key part of providing dementia friendly care. A dementia friendly environment can help people be as independent as possible for as long as possible. People were able to wander around the service. The physical layout of the residential area of Heffle Court was helpful to people who liked to walk as they could walk all around the area without coming to a dead end. People who could walk could also go outside into the courtyard garden if and when they wanted to. Guidance had been sought with regard to making the environment more user friendly and comfortable for people living with dementia. We were shown a number of initiatives to stimulate people living with dementia. These included rummage areas with wardrobes and drawers which people could explore the contents of, an area made up to be an old post office that people could wander through and look at reminiscence items in the post office. The hairdressing salon was set up in the style of a 1950's hairdressing salon, and there was a tea shop and bar area which was run once a week by volunteers.

Staff ensured they asked people if they were happy to have any care or support provided. For example, we observed care staff talking with people about when they would like help with their personal care. Staff were informing and encouraging people to take part in the activities arranged on that day. One care staff told us when they first started to work in the service, "It was like walking into someone's home. "Staff provided care in a kind, compassionate and sensitive way. They answered questions, gave explanations and offered reassurance to people who were anxious. One visitor told us their relative, "Is terribly agitated but very well cared for. The staff reassure her however often she needs it." Staff responded to people in politely, giving them time to respond and asking what they wanted to do and giving choices. We heard staff patiently explaining options to people and taking time to answer their questions. Staff were attentive and listening to people. For example, one staff member got down to eye level in order to talk to someone in conversation. There was a close and supportive relationship between them. Even though staff were very stretched in the lunchtime period, they did not let this affect the way they spoke with people, nor did they hurry people to make decisions. Visitors told us they had noted the same during the lunch time period. One visitor told us, "I've seen the staff being kind to people – they have endless patience." Another visitor told us, "I've never seen any staff be uncaring or dismissive – they have a good attitude."

People were consulted with and encouraged to make decisions about their care. They also told us they felt listened to. People were addressed according to their preference and this was mostly their first name. Staff spoke about the people they supported fondly and with interest. People's personal histories were recorded in their care files to help staff gain an understanding of the personal life histories of people and how it affected them today. Care staff demonstrated they were knowledgeable about their likes, dislikes and the type of activities they enjoyed. Staff spoke positively about the standard of care provided and the approach of the staff working in the service. One member of staff told us, "Choice is the most important thing." Another member of staff told us, "It's completely up to the residents. It's the people's home."

People had a great deal of independence. They decided where they wanted to be in the service, what they wanted to do, and deciding when to spend time alone and when they wanted to chat with other people or staff. People were where possible were involved in making day to day decisions about their lives. Visitors told us they felt care staff treated their relative with dignity and respect. The registered manager was a 'Dignity Champion,' and information about dignity and respect and what people

Good

Is the service caring?

should expect was available for people and their visitors to read in the service. They had used the information they had gained through being a dignity champion to help ensure this was highlighted and clear what people should expect from the care provided. Care staff had received training on privacy and dignity and had a good understanding of dignity and how this was embedded within their daily interactions with people. They were aware of the importance of maintaining people's privacy and dignity, and were able to give us examples of how they protected people's dignity and treated them with respect. One care staff told us when they assisted people with their personal care, "Some people will only have female carers. I ensure we close the curtains and the door to the bathroom. I use a towel and cover people up."

The atmosphere in the service was calm and relaxed, but there was also a general hum of activity. People had their own bedroom and ensuite facility for comfort and privacy. They had been able to bring in items from home to make their stay more comfortable such as small pieces of furniture, pictures and ornaments. People's bedrooms were personalised, with a range of ornaments, photographs, picture, CDs etc. People's names were on their doors and which incorporated images of people and places that were important to people to help them recognise their room. People had been supported to keep in contact with their family and friends. Visitors told us there was flexible visiting, and care staff were always friendly and welcoming to them: One visitor commented, "The staff are friendly, helpful, always chat." Another visitor told us, "The staff are all so friendly and welcoming." For people who wished to have additional support whilst making decisions about their care, information on how to access an advocacy service was available in the information guide given to them. Senior staff were aware who they would contact should people need this support.

Care records were stored securely. Information was kept confidentially and there were policies and procedures to protect people's personal information. There was a confidentiality policy which was accessible to all staff. Staff demonstrated they were aware of the importance of protecting people's private information.

Requires Improvement

Is the service responsive?

Our findings

People were involved in making decisions about their care wherever possible. People were listened to and enabled to make choices about their care and treatment. However, we found areas of practice that required improvement.

Before someone moved into the service, a pre-admission assessment took place. This identified the care and support people required to ensure their safety so staff could ensure that people's care needs could be met in the service. The registered manager told us everyone was visited prior to any admission. If they felt they did not have enough information to make a decision they requested further information. However, For one person we found that they looked very uncomfortable lying in their bed. We spoke with a visitor told us, "None of the chairs suit and his bed is not long enough." This had not been identified as part of the initial assessment of his care needs. We spoke with the registered manager during the inspection about this feedback who told us they would check and ensure that a suitable bed and seating was provided.

On the nursing unit we saw that tables were placed in front of people where they sat. This enabled people to have drinks and items near to them to access. However, we observed when staff were not present to offer assistance it did prevent one person from getting up and walking away. They tried to get up by climbing over the table. We discussed this with staff who removed the table and supported the person to get up. Another person had a slip from their chair in a lounge. Following assistance back into their chair staff placed a table across in front of the person to prevent a reoccurrence. Another person was placed in a chair in the corridor facing the wall. When we asked care staff on duty why this had occurred and were told, they were concerned that the person did not walk on the wet floor and slip.

An activities co-ordinator worked in the service five days a week. Volunteers were also available to help and run activities. On the day of the inspection the co-ordinator was on annual leave, but came in later during the day and facilitated a number of activities for people to join in. We asked staff what activities were available for people to join in when the activities co-ordinator was not on duty. Staff told us it was not usually possible to organise and run activities when the activities co-ordinator was not on duty and at the weekends. So there were times when people were then not able to participate in meaningful activities to help promote their social wellbeing.

We observed an activities session in the morning when the co-ordinator organised a sing-along and played the ukulele. The songs were ones that people could remember and people were offered percussion instruments to join in and play if they wished. The activities co-ordinator led this session skilfully, asking questions that people could answer confidently and sometimes taking her lead from the songs that people were singing. It was clear that people enjoyed this session; including some people who did not join the group, but were also in the room and could hear what was going on and they sang along or tapped their feet. Some people who were quite anxious before the session appeared to be less so as they were distracted by the music. The tea shop opened during the afternoon and people were encouraged to go there for tea. Two people were individually taken out of the service for a walk. We saw they had enjoyed this activity and the opportunity to go out.

Feedback from visitors was good about the activities provided. One visitor told us," 'The staff put themselves out to talk to people, try to keep them occupied." Another visitor told us, "They do lots of activities – they take her out, for fish and chips, and children and dogs come in – she likes all that. "Another visitor told us, "Activities here are very good." There were details of activities planned for people to join in. The notice boards had information about activities people could attend and people were reminded each day of the activities on offer and encouraged to participate. Periodic newsletters also informed people and their relatives of activities which had taken palace and were due to be run. Records of residents meetings and quality assurance questionnaires completed confirmed that people had been asked for their views and ideas on activities which could be provided.

There was a mobile sensory unit which provided soothing music and lights and could be moved to different parts of the service for people to use. Also onsite in the garden was a small farm area called 'Willow Farm.' This provided a therapeutic environment for people to enjoy the company of animals such as chickens, ducks, goats, rabbits and guinea pigs. Formal links with the wider community were

Requires Improvement

Is the service responsive?

encouraged. For example, links with the Alzheimer's Society had been made, and they had provided musical afternoons in the service. We saw that local groups had been invited into the service to interact with people.

Care staff told us that care and support was personalised and confirmed that, where possible, people were directly involved in their care planning. Where people could not be due to their dementia, family had been involved in providing important information to help care staff with the delivery of people's care. The care and support plans were detailed and contained clear instructions about the needs of the individual. They included information about the needs of each person for example, their communication, nutrition, and mobility. Individual risk assessments including falls, nutrition, pressure area care and manual handling had been completed. There were instructions for care staff on how to provide support tailored and specific to the needs of each person. These had been reviewed and audits were being completed to monitor the quality of the completed care and support plans. Where appropriate, specialist advice and support had been sought and this advice was included in care plans. For example, records confirmed that advice and support had been sought from the speech and language team (SALT.)

During our discussions with staff we found that they knew people and their individual needs and it was evident that they knew them well. Staff demonstrated an understanding of non-verbal communication needs and how to interact with people who could not verbally communicate. Staff told us, when offering choice to people who could not verbally communicate; they used facial expression, body language and gestures to communicate. For example, staff could describe how they used a person's body language to describe if they were happy to have their personal care provided. This showed us that people's communication needs were met.

People and their representatives were able to comment on the care provided through regular reviews of people's care and support plans, in residents meetings and by completing annual quality assurance questionnaires. For example there was a four week, seasonally changed menu, which showed choices were available at each meal and further alternatives if needed. Minutes of the residents meetings held confirmed people had been asked for feedback on the meals provided and for suggestions for dishes to go on the menu. There was a sign in the 'post office' asking for 'residents, family and staff' to give feedback, and that the subject for March was 'menus and options'.

People were made aware of the complaints, suggestions and feedback system which detailed how staff would deal with any complaints and the timescales for a response. It also gave details of external agencies that people or their representatives could complain to. This information was contained within the service user's guide which was available in people's bedrooms. People and their visitors told us they felt listened to and that if they were not happy about something they would feel comfortable raising the issue and knew who they could speak with. One visitor told us, "I'd feel happy raising a complaint – with the manager. "Another visitor told us, "I'm confident that the manager will look at what's gone wrong and put it right." Where one visitor had raised a concern they told us, "I asked for a doctor to see her and that wasn't forthcoming – so I complained. Then it was arranged." Care staff were aware that if people or their visitors had any concerns these should be discussed with the registered manager. We looked at the records of any complaints raised and saw the policies and procedures had been followed with issues investigated and written responses of the outcomes sent to the complainant in a timely way. In addition to the compliments and complaints procedure, the registered manager told us they operated an 'open door' policy and people, their relatives and any other visitors were able to raise any issues or concerns.

Requires Improvement

Is the service well-led?

Our findings

The provider had not identified that people's safety was potentially at risk from inadequate staffing levels that impacted on care delivery and raised potential risks to people's safety. Staff felt that low staffing levels at times stopped them giving the care they wanted to. On the day of the inspection it was particularly difficult as the staff team were working with one less member of care staff and one less domestic staff than usual. Some care plans were lacking in specific guidance in the care delivery that had the potential to cause harm to the individual. The care plan audits had not identified that people's specific health needs were not accurately reflected in their care plans, for example management of epilepsy, mobility and continence. Medication audits had not identified the lack of guidance in respect of covert administration of medicines.

Staff and visitors had an awareness of the management team but felt that staff turnover and use of agency staff had unsettled the running of the service. As we saw on the day of the inspection the staff worked hard, but shortcuts in care delivery and the management of risk were seen due to time constraints and staff shortages. On the day of the inspection, Heffle Court was one care staff short, one kitchen assistant short for part of the morning and a cleaner was on annual leave. This impacted on the care we observed being delivered and the delegation of staff at times impacted on the staff safety. This meant people did not receive the care they wanted and required. For example personal care, mental stimulation and promotion of independence and mobility. We looked at the duty rota and noted that some senior staff were working excessive hours to cover the staff shortages.

This meant that the people had not been protected against unsafe treatment by the quality assurance systems in place. This was a breach of Regulation 10 of the Health and Social Care Act 2008, which corresponds to Regulation 17 of the Health and Social Care Act 2014.

There was signage around the service to help direct people. However, some of the signage was small to see particularly for people who also had visual impairment.

We recommend that further guidance is sought with regard to signage making the environment more user friendly and comfortable for people living with dementia.

There was a clear management structure with identified leadership roles. The registered manager was supported by a deputy manager, registered nursing staff and two experienced senior care staff. The senior staff promoted an open and inclusive culture by ensuring people, their representations, and staff were able to comment on the standard of care provided and influence the care provided. Staff told us they felt the service was well led and that they were well supported at work. The registered manager was very hands-on, approachable, knew the service well and would act on any issues raised with them. One member of staff told us, "She is very friendly. She will come and help with personal care." Another member of staff told us, "She is very approachable. If I am not sure about something, I know I can go to the manager. "Another member of staff told us, "We have a very good senior. I can go and chat to her." Another care staff told us, "We all look after each other. The seniors are both absolutely amazing. They are really supportive." Feedback from the visitors was varied when asked about the management arrangements for the service. One visitor told us, "I know the manager – all very accessible." Another visitor told us, "I know the manager – but don't see her often."

The organisation's mission statement was incorporated in to the recruitment and induction of any new staff. The mission statement was detailed in the service user's guide for people, visitors and staff to read. The aim of staff working in the service was, "To provide high quality nursing and residential care that will together with a day to day programme of agreed meaningful activity enable the residents to maximise their independence, pursue personal development, meet their religious needs, and ensure that individual requests are met as much as possible in a shared living environment.' Staff demonstrated an understanding of the purpose of the service, with the promotion and support to develop and maintain people's life skills, the importance of people's rights, respect, diversity and an understood the importance of respecting people's privacy and dignity. We were told by staff, and the visiting professional there was on open culture at the service with clear lines of communication. All the feedback from visitors and staff was that they felt comfortable raising issues and providing comments on the care provided in the service. The visiting professional told us the communication between the staff team was good, with guidance and changes to people's care and support needs being followed through.

Requires Improvement

Is the service well-led?

Staff meetings were held throughout the year. These were used as an opportunity to both discuss problems arising within the service, as well as to reflect on any incident that had occurred. Staff told us they felt they had the opportunity if they wanted to comment on and put forward ideas on how to develop the service. The registered manager told us they were well supported by the provider, through supervision and they regularly met other registered managers from across the organisation. There was a new regional manager in post who travelled down on the day to be part of the inspection. Senior staff carried out a range of internal audits, including care planning, medication, health and safety, infection control and staff training. They were able to show us that following the audits any areas identified for improvement had been collated in to an action plan and how and when these had been addressed. The registered manager had regularly sent statistical information about the care provided to the provider to keep them up-to-date with the service delivery. We looked at the last report which gave the provider information on staffing, incident and accidents, complaints and the maintenance of the premises. The provider's representatives had also undertaken periodic quality assurance visits to look at the quality of the care provided. We looked at their last report following their visit. This detailed where it had been found the service was working well and where it was felt further improvements could be made in relation to the required standards with a timescale for this to be implemented. For example the registered manager was to ensure new records were used to evidence staff training which had been completed and that recruitment information for new staff was kept in the service to show the recruitment process followed. We spoke with the registered manager who has told us that where actions had been highlighted these had been included in the annual development plan for the service, and worked on to ensure the necessary improvements.

Accidents and incidents were looked at on an individual basis and action taken to reduce, where possible, reoccurrence. People's individual care and support needs were reviewed when incidents occurred to help keep them safe. For example, when people experienced falls that resulted in injuries, the manager reviewed the individual accident records and made changes to the care that they received.

Systems were in place to gather the views of people and their relatives on the quality of care provided. This was through reviews of the care provided, regular residents meeting and with the completion of quality assurance questionnaires. Quality assurance questionnaires had just been sent out. The overall response was that 85% stated the service was very good, and 100% stated they would recommend the home to other people. The action plan had not yet been drawn up to address any issues highlighted. But we saw that the expectation form the provider was that all action points would be addressed within six weeks and the quality manager within the organisation would be monitoring this. The registered manager was able to provide us of examples of when changes had been made following feedback received. For example, there had been changes to meals on the menu.

The registered manager understood their responsibilities in relation to their registration with the Care Quality Commission (CQC). Senior staff had submitted notifications to us, in a timely manner, about any events or incidents they were required by law to tell us about. Policies and procedures were in place for staff to follow, and current guidance had been used to regularly update policies and procedures.

A periodic newsletter that detailed the year's events was produced that included the use of colour photographs. This made the newsletter more visually appealing to people with poor vision or dementia and helped them to keep informed.

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 18 HSCA (RA) Regulations 2014 Staffing **The registered person had not ensured there were always sufficient numbers of suitably qualified, skilled or experienced persons employed.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The provider had not ensured that care had been provided in a safe way for people.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance **The registered person had not ensured there was adequate assessment and monitoring of the quality of service provision.**