

SeeAbility

# SeeAbility - Heather House Nursing Home

## Inspection report

Heather House  
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Tadley  
Hampshire  
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Website: [www.seeability.org](http://www.seeability.org)

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## Ratings

### Overall rating for this service

Good 

Is the service safe?

Good 

Is the service effective?

Good 

Is the service caring?

Good 

Is the service responsive?

Outstanding 

Is the service well-led?

Requires Improvement 

## Overall summary

We inspected SeeAbility - Heather House Nursing Home on 15 and 17 July 2015. This was an unannounced inspection.

SeeAbility - Heather House Nursing Home consists of two purpose built ground floor units and is set in a wooded site on the outskirts of Tadley. Facilities include a sensory

suite, indoor hydro pool, Jacuzzi baths and other specialist activity rooms. The home also provides a guest suite for visiting families to promote family relationships and maintain family links.

SeeAbility - Heather House Nursing Home is a residential nursing home providing specialist care for up to 16 young adults with degenerative conditions. These include

# Summary of findings

Juvenile Batten disease (JBD). They also support individuals who have complex physical and learning disabilities. At the time of the inspection there were 14 people living in the home with varying degrees of visual impairment, moderate to severe learning disabilities and healthcare needs. Some people had very limited verbal communication skills and they required staff support with all aspects of their personal care, nutrition, mobility and to go into the community.

Ten of the 14 people in the home were living with JBD. The provider's webpage notes 'Batten disease describes a group of rare inherited neurodegenerative disorders that occur in children and adults. Juvenile Batten disease usually begins at early school age. It often begins with vision problems. Later short-term memory loss, epilepsy, motor problems and declining school progress becomes apparent. Life expectancy is limited to between late teens and mid thirties'.

The registered manager was a trustee of the Batten Disease Family Association. They worked with scientists and healthcare professionals to share expertise in Batten Disease as any advancements have potential benefit for people living at Heather House. Staff had improved their understanding and treatment of epilepsy of people with JBD at the home following this joint working.

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

Staff knew people well and supported them appropriately to stay safe and well. However, people's records did not always include all the information staff required to know how to manage risks to people's health and how decisions relating to people's care had been made. The provider was employing new staff and had increased the use of agency staff. An accurate, up to date record of people's care and risks was required to ensure staff, who did not know people well, would know how to support them appropriately without being overly reliant on the support of experienced staff.

Quarterly quality monitoring visits were undertaken by senior management. However, the quality assurance

systems implemented by the registered manager between the quarterly provider visits were not sufficiently robust for such a complex, high risk service. Regular health and safety checks were carried out to ensure the physical environment in the home was safe for people to live in.

There was a nurturing atmosphere within the home and staff put people at the heart of the home. People and their relatives were encouraged to be involved in the planning of care. Staff were motivated and flexible to ensure people's plans were realised, and that they had meaningful and enjoyable lives.

Staff had a positive approach to keeping people safe. Staff showed commitment to managing people's changing risks. Staff were familiar with the health risks people living with JBD faced and nurses knew how to respond if people experienced health emergencies. People had varying levels of independence in meeting their own nutrition and hydration needs. Several people required the use of a Percutaneous Endoscopic Gastrostomy (PEG) to receive nutrition. When a person was having ongoing and serious trouble swallowing and couldn't get enough food or liquids by mouth, a feeding tube was put directly into the stomach through the abdominal skin. This procedure is called a percutaneous endoscopic gastrostomy (PEG). Staff were skilled in managing people's PEG nutrition appropriately in line with professional guidance and checked that people's PEGs were used safely.

All of the staff received training that provided them with the knowledge and skills to meet people's needs in an effective and individualised manner.

Relatives we spoke with told us people received excellent health care at SeeAbility - Heather House Nursing Home. People living with JBD had ongoing complex health needs and they received timely support from appropriate health professionals. This included support from the provider's physiotherapy team and speech and language therapist; and established access to a range of community healthcare resources including; dietician; occupational therapist and wheelchair services. A local GP visited the home weekly to monitor people's health needs. People's health was reviewed as needed and staff implemented professional's guidelines appropriately. Systems were in place to ensure people received their medicines as prescribed.

# Summary of findings

The registered manager and staff's response to people's complex health needs, was outstanding. Staff found creative ways to maintain people's skills and independence. Staff proactively supported people living with JBD to retain their muscle, communication and social function. The home had a purpose built activity centre where people were supported to engage in a variety of leisure and therapeutic activities. Staff told us that people's loved ones were an integral part of care for people and care and support was extended to them as well. Accommodation was available to people's relatives at the home and creative ways were used to support people to stay in touch with their loved ones.

Staff sought people's consent before they provided care and support. However, some people were unable to make certain decisions about their care. In these circumstances the legal requirements of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS) were followed. Where people had restrictions placed upon them to keep them safe, the staff ensured people's rights to receive care that met their needs and preferences were protected. Where people were legally restricted to promote their safety, the staff continued to ensure people's care preferences were respected and met in the least restrictive way.

People and their relatives were involved in the assessment and review of their care. Staff supported and encouraged people to access the community and participate in activities that were important to them.

Feedback was sought from relatives and people and used to improve the care. People knew how to make a complaint and these were managed in accordance with the provider's complaints policy.

The culture of the home was nurturing and supportive. People were treated with kindness, compassion and respect, and staff promoted people's independence and right to privacy. The staff were highly committed and provided people with positive care experiences. They ensured people's care preferences were met and gave people opportunities to try new experiences.

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

The home was safe.

People felt safe. Staff understood their responsibilities around safeguarding and knew how to raise concerns.

Staff identified and managed the risks of people's care.

People received their medicines safely.

There were enough staff to meet people needs safely.

Good



### Is the service effective?

The home was effective.

People with ongoing complex health needs were supported by skilled staff to access the health support they needed to enable them to lead an improved quality of life.

People received effective care from staff who were trained in providing service specific care to meet people's individual needs.

The registered manager acted in line with current legislation and guidance where people lacked the mental capacity to consent to aspects of their care or treatment.

Good



### Is the service caring?

The home was caring.

People were treated with kindness, dignity and respect. People and a relative said staff were very caring and considerate.

People had complex communication needs associated with their disabilities. Staff used a range of communication methods appropriate to each person's needs to understand their preferences.

People were supported to maintain family relationships and to avoid social isolation.

Good



### Is the service responsive?

The home was responsive.

Creative, tailor made techniques were used to support people with communication difficulties to express their views, concerns and take part in planning their care. People consistently lead their lives the way they wanted to.

Outstanding



# Summary of findings

The home had a purpose built activity centre and people were proactively supported through a range of activities to retain their muscle, communication and social function. People had a choice about their daily routines and activities were flexibly supported.

People, relatives and staff were encouraged to express their views and the service responded appropriately to feedback.

## Is the service well-led?

The home was not consistently well-led.

People's care records were not always accurate and comprehensive to ensure staff who did not know people well had the information they needed to support people appropriately.

Quarterly quality monitoring visits were undertaken by senior management. However, local assurance systems were not sufficiently robust to proactively monitor the quality or risk management for this complex, specialist nursing home.

There was a nurturing atmosphere and staff told us people were at the heart of the home.

The registered manager was a trustee of the Batten Disease Family Association and the expertise in Batten Disease shared as a result had improved the treatment and understanding of epilepsy in people with JBD at the home.

**Requires Improvement**



# SeeAbility - Heather House Nursing Home

## Detailed findings

### Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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 inspection took place on 15 and 17 July 2015 and was unannounced. This is a small service and the inspection was undertaken by two adult social care inspectors in order to minimise the disruption to people's routines.

Before the inspection we reviewed the information we held about the service. This included previous inspection reports, statutory notifications (information about important events which providers are legally required to notify us by law) other enquiries from and about the provider and other key information we hold about the service such as previous inspection reports.

The provider completed a Provider Information Return (PIR). The PIR is a form that asks the provider to give some key information about the service, what the service does

well and what improvements they plan to make. At the last inspection on 18 December 2013 the service was meeting the essential standards of quality and safety and no concerns were identified.

We spoke with two people who were able and wanted to speak with us. We were only able to have limited talks with some people living in the home due to their communication and language difficulties associated with their physical and learning disabilities. For these people we relied mostly on our observations of care and our discussions with people's relatives and the care staff to form our judgements.

We spoke with two people's relatives and one person's advocate. We interviewed the registered manager. We also spoke with the activity resource coordinator, the volunteer coordinator, the regional learning and development officer, one deputy manager, two volunteers, six care workers, two housekeeping staff and three nurses. After our inspection we spoke with the regional service manager as well as the provider's rehabilitation officer and Speech and Language Therapist for the region. We observed how staff supported people, reviewed three care plans, four recruitment files and other records relevant to the management of the service such as health and safety checks and quality audits.

# Is the service safe?

## Our findings

One person told us they felt safe living at SeeAbility - Heather House Nursing Home. People's relatives and a visiting advocate did not have any concerns about abuse or bullying from staff or other people living in the home. Visiting professionals and their relatives told us they were encouraged to share any safety concerns with the registered manager and told us they would be confident speaking to a member of staff or the registered manager if they had any concerns. We observed that people looked comfortable and relaxed with the staff, volunteers and with each other.

The provider took action to minimise the risks of avoidable harm to people from abuse. Staff told us they had received safeguarding training and were able to describe what could be classed as abuse, for example; neglect, physical or mental abuse. They were also able to tell us what would alert them to the possibility that someone had been or was being abused. Staff were able to explain their reporting policy if this occurred. They were confident that the registered manager would take action if they raised concerns. One care worker said "I had reported a safeguarding concern to the manager in the past, it was dealt with straight away". Safeguarding and whistle blowing policies were also available and staff were aware of the information these contained. Whistle blowing is a way in which staff can report misconduct or concerns they have within their workplace.

Where people found it difficult to manage their money independently, the provider had systems in place to support people appropriately and to protect them from financial abuse. This included systems for documenting money which was held, and spent, by people living in the home. Staff were familiar with the home's money management systems and these were checked during each shift to ensure all monies were correct. The regional service manager had checked how people's money was being managed as part of her last quarterly monitoring visit on 22 June 2015 and had found no concerns.

We spoke with staff about how they kept people safe and one care worker told us, "Each service user has different needs that we need to be aware of in order to keep them safe". The registered manager told us and we saw that people's risk management plans were being rewritten in a new format. Nurses were still developing their skill in

ensuring the new records were comprehensive and included all people's risk management plans including risks to their health, mobility and use of equipment. Though some of the risk management actions staff told us about had not yet been incorporated into people's care plans, all staff we spoke with had in-depth knowledge of people's needs and how to keep them safe.

Guidance was available to staff on what to do if health emergencies occurred. For example, protocols had been agreed with the GP for responding to each person who had seizures. Nurses had a good understanding of the action they needed to take if people experienced prolonged seizures. Staff told us they would call the emergency ambulance service or speak with the person's GP, as appropriate, if they had concerns about a person's seizure activity. The service had developed a protocol to support staff to safely manage seizures in people living with Juvenile Batten disease (JBD) as traditional treatment options might not always be effective.

People living with JBD, who had lost their ability to swallow, received specially formulated nutrition through tubes. When a person was having ongoing and serious trouble swallowing and couldn't get enough food or liquids by mouth, a feeding tube was put directly into the stomach through the abdominal skin. This procedure is called a percutaneous endoscopic gastrostomy (PEG).

People who required PEG nutrition only received support from staff who had received training and had been assessed as competent to safely deliver tube nutrition. Staff were familiar with the risks associated with tube nutrition including how to flush tubes with water before and after use, as they blocked easily. People's risk of burns relating to gastric reflux from their nutrition tubes had been identified, and we saw staff ensured people were sat upright whilst eating and after as required by their risk management plans. People were provided with special beds to enable them to sit up when in bed to prevent gastric reflux.

The service's physiotherapist worked in conjunction with the local wheelchair service occupational therapist (OT) to assess people's mobility support needs and their risks when using wheelchairs or hoists to transfer people from their bed or chair. Staff were able to describe how they would record and report any accidents whilst supporting people to move in line with the provider's incident and accident procedure. They told us following a moving and handling incident the OT re-assessed whether a person's



## Is the service safe?

support and equipment was safe. The OT added a wheelchair strap to further increase the person's safety when using their wheelchair. The registered manager told us staff were quick to identify potential risks when supporting people to mobilise and promptly requested guidance from the physiotherapist if required.

Regular health and safety checks were carried out to ensure the physical environment in the home was safe for people to live in. The registered manager with the support of maintenance staff carried out a set programme of weekly and monthly health and safety checks. These included, fire safety equipment checks and checks to the water system. The Registered Manager completed health and safety and fire risk assessments which were subject to 6 monthly review. The provider's central team supported this process and also carried out a health and safety audit of the home on a 12-18 month basis, or more frequently as required. A range of health and safety policies and procedures were in place to help keep people and the staff safe. Suitably qualified contractors were used to inspect and maintain the home's gas, electricity and fire safety systems. Emergency plans were in place in the event of a fire at the premises or for incidents that may impact on the service's ability to deliver people's planned care. Records showed the registered manager had completed the health and safety actions identified at the quarterly monitoring visits including auditing the home's water safety folder and ensuring fire drills were planned for the coming year.

There were effective recruitment and selection processes to reduce the potential risks to people living in the home from unsuitable staff. Recruitment was organised through the provider's central human resources department. Appropriate checks were undertaken to identify if applicants had any criminal convictions or had been barred from working with vulnerable adults. Staff were not allowed to start work until satisfactory checks and references from previous employers were obtained. This information was not always evident in staff files; however the manager checked with staff in the head office and proof was obtained that these checks had been completed.

The nurses demonstrated that they had a clear understanding about the medicines people took, such as what, when and how they should be taken. We also saw

that the nurses spoke with people in a friendly manner and treated people with respect and dignity when giving them their medicine. When one person was shown their medicine and told what it was for, they nodded and smiled at the nurse in acknowledgement. This showed us that, where possible, people knew about their medicines and were involved in their administration.

Each person's medicine was kept inside a lockable cupboard in the treatment room and people's medical records contained clear and detailed information, including the person's date of birth and details of any allergies. The Medicine Administration Records (MAR) we looked at had all been completed appropriately. Nurses disposed of any unused medicine safely.

There were enough staff to meet the needs of people and to keep them safe. We observed that staff were available to support people whenever they needed assistance or wanted attention. Each unit had a nurse on duty during the day and care staff told us nurses were experienced and knew what to do if people suddenly became unwell. The registered manager kept the staffing under review and staffing was adjusted to meet people's needs. For example, additional staff were deployed to meet the needs of people who were new to the home to give staff the time to get to know them. People and staff told us they felt the number of care staff was sufficient to look after people's routine needs and support people individually to access community activities.

The provider had increased the use of their own bank staff and agency staff to cover recent staff vacancies. The registered manager was actively recruiting to fill these vacancies. Agency staff were at times sourced at short notice to cover unplanned staff absences and they did not always know people well. A senior support worker told us a system was in place to reduce the risk to people when supported by agency staff who did not know their risk management plans well. These included, ensuring agency staff never worked alone or with other agency staff, and that they were supervised at all times by a permanent worker. Agency staff were not used for one to one support so that people with complex support routines would be supported by staff that knew them well.



# Is the service effective?

## Our findings

During the inspection we observed people received care and support in line with their care plans. Staff understood people's needs and we saw they were competent and confident when supporting people throughout our visit. Professionals and relatives told us staff knew how to support people appropriately.

Staff told us they received tailored training and mentoring to ensure they knew how to effectively support and care for each person's health and emotional needs. Most of the training was delivered by the provider's central training team but outside specialists were brought in where appropriate. This training was interactive to give staff a greater understanding of the challenges people faced in their daily life. One member of staff said, "The PEG training was really good. We had to make up people's meals on three occasions and the manager observed us to see if we did it correct. She then signed that we had the skills to do it". The provider's rehabilitation officer told us as part of their visual impairment training they asked staff to carry out tasks blind folded to gain an appreciation of how life is for the sight impaired people they support.

Staff told us the provider supported them to take further qualifications such as the Diploma in Health and Social Care. The registered manager said all new staff received an intensive induction programme and were assigned an experienced member of staff as a mentor. Staff told us they worked alongside their mentor until they achieved the required levels of competency. One support worker told us "It is all about competence. You have had to support people with eating for at least a year before you are deemed competent to move up to supporting people with more complex tube feeding". This ensured people received effective care from staff who had the necessary level of knowledge and skills. Volunteers told us they received sufficient training and support from the volunteer coordinator to enable them to fulfil their role. Nurses told us they received sufficient opportunities to comply with the continuous professional development requirements of their registering body.

Staff said everyone worked well together as a supportive team and this helped them provide effective care and support. Staff told us one of the challenges they faced was

dealing with the death of people in the home as JBD has no cure. One nurse told us "We receive support to deal with our loss and to help us to develop our skills in supporting families and each other".

Care practices were discussed at monthly one to one supervision sessions and team meetings with the manager. Staff told us this also gave them the opportunity to identify and discuss solutions to problems, improve care practices and to increase understanding of work based issues. One support worker told us "Supervision is always helpful and on time. I have just had my appraisal and I have set goals I want to achieve by September". Annual performance and development appraisal meetings took place to identify and address staff training and development needs.

Staff understood the requirements of the Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards (DoLS). The provider followed the MCA 2005 code of practice to protect people's human rights. The MCA 2005 provides the legal framework to assess people's capacity to make certain decisions at a certain time. Staff knew how to support people with decision-making to enhance their participation. One support worker told us about a person who has 'bad' days and may not be able to answer questions on those days. She told us "However, we know that tomorrow they may be answering every question under the sun so we always offer them choice and information". Records showed capacity assessments and best interest decisions had been made for people who could not consent for example, to the use of bedrails, wheel chair straps, their end of life care or taking their medicines.

Deprivation of Liberty Safeguards (DoLS) provides a process by which a person can be deprived of their liberty when they do not have the capacity to make certain decisions about where they live and there is no other way to look after the person safely. Five people had suitably approved DoLS authorisations in place. The manager told us all people except one in the home, were potentially being deprived of their liberty and that applications had been submitted to the local authorities of the eight other people to authorise these arrangements.

People had varying levels of independence in meeting their own nutrition and hydration needs. These needs were well described in their support plans. For example, some people were being supported to eat a healthy and balanced diet, whilst others had more specialised needs such as the use

## Is the service effective?

of a PEG to receive nutrition. There were clear guidelines on file for staff to follow in relation to the PEG. Staff described how they prepared people's PEG nutrition and the amount of hydration each person required. Records showed the community dietician reviewed people's PEG nutrition monthly and people were also weighed monthly to ensure they remained sufficiently nourished. The GP ensured people had chest X-rays if there were any concerns that their PEG tube might have moved.

The provider's speech and language therapist (SALT) visited the home as needed to check people had the support they needed to eat and drink enough. Staff ensured mealtimes were calm and kept noise down to support people with vision impairments to focus on their meal. No one was rushed during their meal and staff checked if people wanted any more to eat or drink before clearing the table. The SALT told us staff appropriately implemented her guidelines. We also saw staff supporting people who were at risk of choking in line with their SALT guidelines ensuring food was moist, cut up and people were offered drinks to support them to swallow.

People who ate were given a choice of meals and we saw during lunch time each person ate something different according to their preferences. Where appropriate, people were supported to take part in the preparation of their meals. People's food allergies were monitored with the weekly menu planner to ensure they did not receive food they were allergic to.

Relatives we spoke with told us people received excellent health care at SeeAbility - Heather House Nursing Home. People living with JBD had ongoing complex health needs and they received timely support from appropriate

professionals. This included support from the provider's This included support from the provider's physiotherapy team and speech and language therapist; and established access to a range of community healthcare resources including; dietician; occupational therapist and wheelchair services. A local GP visited the home weekly to monitor people's health needs. A diary was kept where staff noted any issues they wanted the GP to look into. The registered manager told us "We have worked with this GP for many years and we can see how her understanding of Juvenile Battens disease has supported us to extend people's life expectancy". A consultant neurologist with experience of JBD also visited the home every three months to monitor people's epilepsy and neurological symptoms. Staff told us that the consistent input from health professionals supported them to develop their skills when supporting people living with JBD.

Nurses completed a monthly health evaluation for each person. This summarised for example their seizure activity, skin condition, weight, and general health over the month. This information was used to inform people's annual health review and enabled nurses to identify any changes over time that might indicate a person's condition was deteriorating. People's health action plans and hospital communication passports provided important information to help external professionals understand people's needs. People's communication passports also made staff aware of how people who do not communicate using speech may express pain. Staff told us this may include people becoming agitated, restless or tearful. How people presented health symptoms was also documented in their healthcare files. This enabled staff to monitor changes in a person's well-being and seek medical advice promptly.

# Is the service caring?

## Our findings

We received positive feedback about the way staff treated people. One person's relative said, "Staff are brilliant with me and with him". Another relative told us "They really know what my daughter likes and always speak with her even if she has difficulty expressing herself". There was a family atmosphere amongst people living in the home and staff told us they encouraged people to get to know each other.

We observed interactions between staff and people and these were patient, supportive, kind and friendly. For example, staff involved and adapted activities in the home so each person was able to participate. There was a lot of friendly chat and people appeared to be having fun and enjoying themselves. Staff responded promptly to people requesting assistance and they did so in a patient and attentive way.

Staff had developed caring relationships with people. They spoke about people warmly showing that they held them in high regard. One volunteer told us "I get the time to develop relationships with people, I never anticipated that I would care so much for them". They also demonstrated a detailed knowledge of people as individuals and knew what their personal likes and dislikes were. Staff showed respect for people by addressing them using their chosen name, maintaining eye contact and ensuring they spoke to people at their level, seated and not rushed.

People and their relatives were treated with compassion. One relative told us "They always know when she has deteriorated and try to support me to adjust". We observed staff spoke to people politely and kindly, offering people company and choice in what they wanted to do. They did not rush people to undertake tasks and checked that the person was happy with the pace they were working at. Staff informed and asked people before they moved them in their wheelchairs.

Staff also assisted us to communicate with people who could not express themselves verbally. People appeared to

understand when staff spoke with them and often responded with smiles or sounds which indicated they were happy. Staff gave people the time they needed to express themselves and maintain their speech. When people became distressed they were promptly comforted with staff chatting to them and reassuring them with a soft voice and touch till they seemed settled. Each person had a designated circle of support which included nurses and care workers, with particular responsibility for ensuring the person's needs and preferences were known and respected by all staff. The person's circle of support understood how to engage with the person to promote their preferred routines and wishes. This helped ensure consistency of care and that people's daily routines and activities matched their individual needs and preferences.

Staff treated people with dignity and respect and supported them to maintain their privacy and independence. We observed staff spoke to people in a respectful and caring manner and were sensitive to people's moods and feelings. Staff told us like all young people at times liked to be alone in their room. We saw staff gave people the opportunity to spend time on their own doing the things they liked. When people needed support staff assisted them in a discreet and respectful manner, for example when people needed personal care. When personal care was provided this was done in the privacy of people's own rooms.

Staff respected people's confidentiality. Staff treated personal information in confidence and did not discuss people's personal matters in front of others. Confidential information about people was kept securely in the office. People were supported to maintain relationships with their relatives and friends. Relatives were encouraged to visit as often as they were able to, and staff supported people to visit their families and friends on a mutually agreed basis. This meant that people were encouraged to maintain personal relationships and were protected from the risk of social isolation.



# Is the service responsive?

## Our findings

SeeAbility - Heather House Nursing Home pro-actively supported people living with JBD to retain their muscle, communication and social function. The home had a purpose built activity centre where people were supported to engage in a variety of leisure and therapeutic activities. Each person attended physical therapy sessions during the week supported by physiotherapy assistants. These sessions included activities in the centre's hydro-pool or gym developed by the physiotherapist to support people to move and enjoy being active as part of their therapeutic programme. We observed one of the hydro-pool sessions and the person's smile and relaxed manner indicated they were enjoying the experience. The staff were aware that some people enjoyed the sensation of water and ensured people were given time to relax in the hydro-bath and double Jacuzzi room in the home during their bath time when they wished.

Staff understood the need for young people to stay in contact with their parents. As this is a specialist service people's families lived all over the country and were not always able to visit regularly. The registered manager had developed creative ways for families to stay in touch. People had electronic devices to enable them to send emails to their relatives as well as talk with them through video link. During our inspection we saw a person's grandmother was reading her a book via an electronic voice link. Her mother told us this was a regular activity and helped her daughter and grandmother maintain their strong relationship. The provider had also built a flat at SeeAbility - Heather House Nursing Home for families to stay in so they could be close to the person when they visited. Staff told us the flat was very popular and had significantly reduced the cost of accommodation for families. One relative told us they regularly stayed in the flat. They told us "It is possible for me to stay here and really be part of my son's day to day life just like I would have been if he wasn't ill". When people went on holiday with their families, staff went with them to ensure people's needs were supported. Staff told us that people's loved ones were an integral part of care for people and care and support was extended to them as well. In this way, people were enabled to maintain relationships that were important to them.

The home used assistive technology to find creative ways to enable people to live as full a life as possible and to increase each person's control over their environment and involvement in activities. Assistive technology refers to a range of devices that help someone to do something they would have difficulty with otherwise. For someone with visual impairment this may include computer software and hardware, magnifiers, CCTV and daily living aids. For example, some people had devices that enabled them to control their TV and music with their voice. We saw people choosing to spend time in their room watching TV or listening to their choice of music that they had selected and activated independently. An interactive music suite was available for people to use in the home's activity centre. This suite had electronic music beams that made a sound when people broke them with a pad which could be placed on any part of the person's body that they could control. Staff also supported people to create a video library of them singing or doing things that they enjoyed and might not be able to do in the future as their health deteriorated. The registered manager told us "This video diary gives people the opportunity to create memories for them and their family".

People were supported to participate in a range of social and leisure activities in line with their personal interests. These included trips out, cooking, gardening and being read to. Two support workers were exclusively allocated to support people's social and leisure programme every day. The activities coordinator developed a rolling six week programme with people's input for support workers to deliver. Support workers told us this helped them to always have ideas of activities to offer people. The programme was flexible and people could do something else if they chose. Staff planned people's activities according to their ability and stamina to ensure people were given the best opportunity to participate. Adjustments were made throughout the day so people would not lose out on activities. For example, staff told us how they had moved people's swimming sessions later in the day when they had been tired or did many short activities with people who tired easily. One support worker told us "We are becoming more flexible, activities are now built around people and changed the whole time. We do not have set times for activities anymore, we do them when people want and can".

The registered manager had also changed the way the home used volunteers to enhance people's social



## Is the service responsive?

relationships and community involvement. The volunteer co-ordinator told us “In the past we used volunteers to support people with specific activities which meant if the person wasn’t well or it rained then they could not do the activity. We now match people with volunteers and it is up to them to decide together what they want to do with their time. People now each have at least two volunteers that visit them regularly and over the past two months we have had 67 volunteer visits”. She gave us an example of how a person had built a good relationship with their volunteer and this had supported them to develop their confidence when out in the community. A support worker told us “The volunteer has really enhanced her life, she is happy to go out with her everywhere”.

Relatives told us they had been involved in developing people’s support plans, were kept regularly updated and were involved in six monthly reviews. Reviews included professionals involved in the people’s care, which meant that people’s care was adjusted as needed with everyone’s feedback and advice in a timely way. Review meetings were also used as an opportunity to involve people’s circle of support in best interest decisions about people’s treatments and care where they had been assessed as lacking capacity to make these decisions independently. The staff had worked with people through observation, preferred methods of communication, such as using pictures or objects of reference, and regular evaluation to ensure support plans were tailored to people’s individual preferences. Regular meetings were held between people and their key support worker to review the previous month and plan activities and special events for the following month. People were supported by their key workers to understand their care plans. People were also supported to take part in their reviews in a meaningful and appropriate way with the use of pictures and objects of reference.

Staff stayed in regular contact with people’s social workers to inform them of any changes to people’s needs, or if people needed additional support to make important decisions about their accommodation or health treatment. Staff knew how to source independent advocates for people to support with decision making if needed. During our visit one person was spending time with their advocate who was supporting them to prepare for their upcoming review. An advocate is independent of a person’s local council and can help them express their needs and wishes, and weigh up and take decisions about the options available to them.

One relative told us “I can speak with the manager at any time and I usually get a quick response”. The service had an appropriate complaints policy and procedure. The home had received one formal complaint in the past year. This complaint was recorded and responded to appropriately and within agreed timescales.

The registered manager said they operated an open door policy. People and their relatives were actively encouraged to feedback any issues or concerns to them directly or to any member of staff. The home was developing ways of identifying when someone with a communication difficulty had a complaint and how they could be best supported to express their views. People were encouraged to raise issues or concerns through their key worker, their relatives or social workers. Regular residents meetings were held. At the meeting in May 2015 people discussed their food preferences and what activities they would like to include in the social and leisure programme. Staff told us additional opportunities had been created for people to go out in the community.

The provider held Regional Service User Group meetings (known as Quality Action Group) three times a year to obtain the views of people who used the service. Agendas covered new service developments and topics people wished to discuss with the provider. The registered manager told us due to people’s fluctuating health it had become more challenging to support a person to attend the regional day. She had arranged for a representative of the Regional Service User Group to visit the home instead of a representative going to the meeting. This way people were able to contribute their views.

People using the service and their relatives were asked to give their feedback about the service through completion of a satisfaction survey in November 2014. The registered manager told us the majority of relatives were satisfied with the care and support provided. Following relatives requests from the survey for more information about JBD, the registered manager was arranging a JBD family support group for relatives to include the GP and other health professionals. Some people and relatives found when the dining room was full some people found it distracting and could find it difficult to concentrate on their meal. We saw the provider was making changes to the existing dining room and a separate dining area was being created to



## Is the service responsive?

accommodate people that required a more focused dining experience. The registered manager had used the feedback and comments of relatives, staff and people to improve the service.



# Is the service well-led?

## Our findings

The provider's stated purpose was, "To enrich the lives of people with sight loss and multiple disabilities across the UK". The provider carried out quarterly quality monitoring visits and an annual health and safety audit of the home to check their stated purpose was being implemented and their policies and procedures were effective.

The regional service manager's quarterly monitoring audits had identified some of the concerns we found. However, the quality assurance systems implemented by the registered manager between the quarterly provider visits were not sufficiently robust for such a complex, high risk service. Checks were undertaken informally or not at all. They did not support the registered manager to identify concerns promptly in relation to medicine management, care records, agency staff competence and accidents and incident trends so corrective action could be taken before the provider's quarterly visit. For example, nurses administered a significant amount of medicines which increased the potential of a human error occurring. Nurses told us they undertook a stock check of all medicines weekly and checked at the end of the shift whether each person's MAR had been signed and medicines given. However, these checks had not been recorded. Should issues arise, the registered manager would not be able to assure herself that these checks had been undertaken. She would not be able to identify when an error was made, or who was responsible, so that the risk could be understood and managed effectively.

Effective systems were not in place to check the quality of people's care plans and daily care records so nurses could take prompt action when concerns were identified. The registered manager told us nurses had to review people's daily records monthly as part of their medical evaluation. Robust checks of people's daily records had not been completed. Nurses had not identified the gaps in people's repositioning charts or discrepancies in their fluid charts and had not assured themselves that people's care had been delivered as they had instructed. Nurses took action to resolve these discrepancies when we discussed our concerns with them.

Although the registered manager and staff told us they were up to date with their training the training monitoring records showed some staff required training updates. The current training monitoring system had not supported the

registered manager to effectively monitor the training of staff in the home. Action was being taken to improve the training recording system across the provider's services and the regional learning and development officer was working with the registered manager to ensure staff training was up to date.

A robust system was not in place for the registered manager to be assured that agency staff possessed the skills and knowledge required to support people with complex needs appropriately. Nurses told us they observed agency staff for three to four months before they were judged to be competent to take on more complex support tasks. For example, when support people during lunch time to prevent them from choking. Records were not kept of these skills assessments and the registered manager would therefore not always be able to assure herself that agency staff had the specialist skills required to support people appropriately.

There was a clear procedure for recording incidents and accidents. Any accidents or incidents were documented on a standardised form, action taken was recorded and signed off by senior staff. Incident forms were checked and audited by the operational manager as part of her quarterly monitoring visit. However, daily and monthly analyses were not completed for example, of any infections, wounds, bruises, falls, weight loss and any moving and handling incidents. This meant systems did not support the registered manager to identify any trends of concern in the accidents and incidents that occurred. Though the registered manager could tell us about trends that had recently occurred and the action taken, in the absence of a robust clinical governance system, trends indicative of shortfalls that might only be visible over a longer time period might have been missed.

The registered manager identified the need to develop a robust local auditing system. She noted in the service PIR submitted in September 2014, 'Whilst the Manager/Deputies currently undertake a range of ad-hoc monitoring including reviews of finances /supervisions /medication /support plans, and record within the documents that they have viewed them, consideration will now be given to introducing an audit form to record what has been reviewed and findings and to plan these at regular intervals'. At the time of our inspection this work was still to be completed and embedded in the home's quality monitoring activities.



## Is the service well-led?

Staff knew people well and supported them appropriately to stay safe and well. However, people's records did not always include all the information staff required to know how to manage people's risks and how decisions relating to people's care had been made. For example, changes to one person's care had been made to reduce their risk of bruising. This change had not been documented and staff did not have an up to date care and risk management plan for this person. Another person needed to be repositioned regularly to relief skin pressure. Staff told us how they did this appropriately and the person's skin remained healthy. Their care plan did not inform staff that regular repositioning was required. Staff had not always noted in their daily records when people were supported to re-position, so that nurses could evaluate the effectiveness of their treatment plan. The service was employing new staff and had increased the use of agency staff. An accurate, up to date record of people's care and risks was required to ensure staff who did not know people well, would know how to support them appropriately without being overly reliant on the support of experienced staff.

The provider did not implement robust quality assurance systems to identify risks to the quality of the service provided and did not maintain complete and contemporaneous care records. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had a clear vision and strong values and put these into practice at the service. The provider's stated purpose was, 'To enrich the lives of people with sight loss and multiple disabilities across the UK'. All the staff we spoke with believed that everyone had ability and they taught and empowered people to develop and maintain their skills to lead meaningful and fulfilling lives. We heard many examples of how staff and volunteers demonstrated their understanding of the provider's purpose and values in the care they delivered and how people's lives had been enriched as a result. For example, staff were supporting one person to fulfil their desire to live in their own home as independently as possible.

Staff, professionals and relatives told us that management operated an "open door" culture and were approachable and supportive. The registered manager had been managing the service. The registered manager had been managing the service since it opened in July 1999, having been appointed in 1998 to prepare for it to become

operational. One staff member said, "The manager knows people well and is always providing advice and guidance. She is very knowledgeable and encourages us to ask questions and learn". Though staff were positive about the management in the home they gave us mixed feedback about the effectiveness of communication in the home. Some staff felt communication was given in a timely way whilst others told us it could improve and there was not always enough opportunity to spend time with the registered manager and deputies. The regional service manager told us they were aware that staff wanted regular opportunities to meet with managers. We saw efforts had been made to ensure staff received their supervision and the number of completed supervisions had improved. These were monitored monthly to ensure staff received regular support.

Staff told us they were clear about their roles and responsibilities. Daily handover meetings and monthly staff meetings were used to assign tasks. Support workers told us nurses provided strong leadership on each shift. Nurses felt supported in their role and told us the registered manager respected their clinical judgement. One nurse told us "There have been times that I have put forward an alternative treatment, she has listened to me and agreed with my view".

The registered manager was continually striving to develop practice and improve the service. Staff and the registered manager told us the provider was open to new ideas and identifying areas of good practice from a range of available sources. For example, the provider had signed up to the 'Making it Real' initiative as part of the Think Local Act Personal (TLAP) Partnership. This is a voluntary movement by councils and provider organisations to drive the personalisation in care delivered by adult social care services. We saw staff were supporting people during their key worker sessions to develop "I statements" of the things they would like to do as part of their 'Making it Real' initiative. People had 'I statement' posters to detail the actions needed to achieve their goals. For example, one person had an 'I statement' identifying the things they like to do with their volunteer and the support they needed to do these.

The registered manager was a trustee of the Batten Disease Family Association. They worked with scientists and healthcare professionals to share expertise in Batten Disease as any advancements have potential benefit for

## Is the service well-led?

people living at Heather House. The service used a grant provided by Batten Disease Family Association to collate and share data about incidences and treatment of epilepsy in people with JBD. The findings were presented at the Batten Disease Family Association Conference in November 2014 and published thereafter. Staff had improved their understanding and treatment of epilepsy of people with JBD at the home following this joint working.

The registered manager attended regular national forums to remain up to date with current best practice. These included Palliative Care For People with Learning Disabilities; Voluntary Organisations Disability Group, Together for Short Lives Transition Workforce as well as the local Nursing Homes Association. The registered manager used learning from these forums to inform the transition

work the home did when young people move from children services into the home as well as supporting people to understand and live with the emotional aspect of their diagnosis.

The registered manager worked to ensure people were treated with care when they accessed other services. For example, after experiences of poor care within the hospital the registered manager wrote to the hospital to express concern and request a meeting to discuss the specialist needs of people. A meeting was held involving senior professionals within the hospital which resulted in an improved understanding and agreed actions for future admissions. The registered manager provided training in JBD to hospital staff and further admissions had demonstrated positive outcomes from this work with people having an improved in-patient experience.

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 17 HSCA (RA) Regulations 2014 Good governance
Treatment of disease, disorder or injury	People's care and treatment records were not always accurate or sufficiently comprehensive. Systems to ensure compliance with the regulations were not implemented effectively to identify and act on risks and quality concerns. Regulation 17 (1)(2)(a)(b)(c) (f)