Heanton Limited

Heanton Nursing Home

Inspection report

Heanton
Barnstaple
Devon
EX31 4DJ

Tel: 01271813744

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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?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

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.

This inspection was unannounced and took place on 3 and 6 February 2017. There were 44 people living at the service. When we last inspected on 14 November 2016, in response to some concerns raised by family whose relative lived at Heanton, we found a number of areas where improvements were needed. This included environmental issues and support and supervision of staff to ensure they had the right skills. Following the November focussed inspection we met with the provider and their management and quality assurance team on 18 January 2017 to discuss the improvements needed and future actions to be taken by the service. This included a discussion about how they had prioritised ensuring people's clinical needs were being met and that people were safe. The provider and the staff team are now working on implementing their new model of care via a year long training course to enable staff to understand the culture and ethos of the household model. The provider sent us an action plan showing how they intended to make improvements as detailed within the previous inspection. We used this information as part of this inspection to check how well embedded any new ways of working were and whether this had impacted on the quality of care and support people were receiving.

Heanton is registered to provide nursing and personal care for up to 52 people. They mainly support people with dementia.

The provider has developed and implemented a care model based on the household model of care pioneered in the USA by LaVrene Norton, Action Pact and Steve Shields. This had resulted in the environment being divided into smaller houses to support small group living. Groups were determined based on the stage of the dementia of the person living at the home. There were four 'houses' (distinct areas within the building) which provided care for people at early stages of dementia, and people living with dementia who were experiencing an altered reality. The third area was for people who were living with dementia who were in a repetitive stage and the fourth house was designated for people who were living with advanced dementia. The provider had implemented this model with the support of specially recruited dementia practitioners. This implementation was still work in progress with staff still learning about the model of care and the environment still being adapted to suit each of the four houses.

There was a manager in post who had been the interim manager since July 2016, but had only just put in an application to register with CQC. She had previously been approved as the registered manager at this service, but made the decision to deregister at the start of this year. This was because she had, at the time wanted to take a more hands on role within the home. She said she now felt ready to take on the responsibility of being the registered manager again. A registered manager is a person who has registered with the Care Quality Commission to manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider.

We found there were improvements needed with the safe storage of medicines to ensure they were being stored at the correct temperatures. We were told at the time of the inspection that medicine management had not been audited for up to one year. The provider has since said audit records show there had been some medicine audits but not as frequently as they should be. There were some gaps in the medicine administration records (MARs) which had not been picked up. Supervision records showed the manager had noted gaps in the way as needed medicines had been recorded, but this had not led to a full audit. We heard how two nurses were taking on the lead role of medicine management, which would include audits and quality checks in the near future.

We observed one occasion where, although staff were present there was no oversight on safety during the lunchtime meal. One person who was at risk of choking helped themselves to food and drink which was not suitable or safe for them to have and this resulted in them having a choking episode. We fed this back during the inspection and was assured this was immediately addressed. The provider said they were now having a member of staff in each dining area who was appointed to have an oversight on what each person was given or had access to eat and drink. On the second day of inspecting we saw lunchtimes appeared more organised with regard to ensuring people had the correct meals in a timely way.

There were still some improvements needed to make the environment suitable and comfortable for people. For example, some of the downstairs lounge chairs had an unpleasant odour and were in need of a deep clean. Some bedroom doors still had star locks which although not in use, should not be on doors. Two new bedrooms had been created; the radiators had not been covered to protect people from possible burns from hot surfaces. The star locks had been removed and radiator covers fitted by the following day of the inspection being completed.

Some parts of the home require further refurbishment. However, we also saw some good improvements since the last inspection. The lounge carpet in Bideford lounge had been replaced which had had a big impact on making the room more pleasant, homely and fresh smelling. The corridor between Bideford and Chichester had been extended out by means of knocking down some smaller rooms off the corridor. This had allowed the service to develop an alcove with further seating for people to use. This had also reduced the amount of incidents in this area. Audits of accident and incident reports had showed a reduction in incidents since this additional space had been created. This structural work had impacted in a really positive way and enhanced the living environment.

Care and support was being delivered by a staff group who had the right skills and training. There were sufficient numbers of staff on each shift to ensure people's needs were being met in a timely and responsive way. Each house had at least two to three staff available each shift. In addition there was always one trained nurse and on some days two. Care and nursing staff were supported by a team of housekeeping and maintenance staff as well as chefs and kitchen staff. Staff reported there were sufficient numbers of staff each shift unless there was short notice of staff sickness. Relatives said they had noticed an increase in staffing numbers and were confident people's needs were being met in a timely way.

Staff understood how to support people who were at different stages of their dementia. The household model was working well to promote people's well-being and help staff develop their skills further. For example two staff who worked with people in the later stages of dementia had begun specialist training in best practice for end of life care. This was being completed in affiliation with the local hospice. All staff were being asked to complete a comprehensive induction book irrespective of how long they had worked at the service. This was to ensure all staff understood and were working within the framework of national standards as set by the Care Certificate.

People mattered and staff cared for people in a way which showed empathy, kindness and respect. We saw many examples of staff working with people to reassure them when distressed, providing a hug and talking to people in a compassionate and caring way.

People were supported to express their views and were involved in decision making about their care where possible. Staff understood the importance of offering people day to day choices. For example at mealtimes showing people both main meal options and asking them to choose which one they wanted.

Staff sought people's consent for care and treatment and ensured they were supported to make as many decisions as possible. Staff confidently used the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS). Where people lacked capacity, relatives, friends and relevant professionals were involved in best interest decision making.

People were protected because staff understood what might constitute abuse and who they should report their concerns to. Safe recruitment processes were followed to ensure only staff who were suitable to work with vulnerable people had been recruited.

Care and support was well planned and risks had been assessed so that staff worked in the least restrictive way. People's healthcare needs were well met and staff understood how to support people with changing healthcare needs.

People were supported to enjoy a balanced diet with flexible food and drink options available throughout the day and night.

Systems and audits were being used to help improve clinical outcomes but these had not included medicine management or identified issues in relation to the environment

There were two of breaches of regulations. You can see what action we took at the end of the report.

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

Not all aspects of the service were safe.

Improvements were needed to ensure the environment was safe and clean for people.

Some aspects of medicines management needed improvement. Records were not consistently kept up to date.

Staff managed risk in positive ways to enable people to lead more fulfilling lives, although better oversight was needed during mealtimes to ensure people's safety.

There were enough staff to ensure people's needs were met.

There were safe recruitment processes in place, meaning that staff were suitable to work at the home

Is the service effective?

Good

The service was effective.

People experienced a level of care and support that promoted their health and wellbeing.

People were cared for by skilled and experienced staff. Staff had regular training and received support with practice through supervision and appraisals.

People's consent to care and treatment was sought. Staff confidently used the Mental Capacity Act (2005) (MCA) and Deprivation of Liberty Safeguards (DoLS) and understood how these applied to their practice.

People were supported to eat a well-balanced diet and they had access to health professionals to make sure they kept as healthy as possible

Is the service caring?

Good

The service was caring.

People received care from staff who developed positive, caring and compassionate relationships with them.

Staff were kind and affectionate towards people and knew what mattered to them.

Staff protected people's privacy and dignity and supported them sensitively with their personal care needs.

People were supported to express their views and be involved in decision
making where possible .

Is the service responsive?

Good

The service was responsive.

People received person centred care from staff who knew each person, about their life and what mattered to them. Care, treatment and support plans were personalised.

People were supported to be actively engaged in things which interested them.

Individuals were listened to and their requests were acted upon. Relatives knew how to make their concerns known and were confident in the manager and staff responding to any concerns raised.

Is the service well-led?

Requires Improvement

Most aspects of the service were well-led but some aspects of their quality assurance had failed to pick up on issues which needed addressing.

The service did not have a registered manager, this process was being completed.

The management team led by example and promoted a strong sense of wanting to continually improve.

The culture of the home was open, friendly and welcoming. Relatives, staff and visiting professionals expressed confidence in the management team.

Heanton 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 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 3 and 6 February 2017 and was unannounced. On the first day the inspection team included one adult social care inspector, one pharmacist inspector, a specialist advisor who was a nurse experienced in dementia care and an expert by experience. An expert-by-experience is a person who has personal experience of caring for someone who uses this type of care service. During the first day we spent time observing how care and support was being delivered and talking with people, their relatives and staff. We met with most of the people living at the home. We spent time in communal areas of the home to see how people interacted with each other and staff and to help us make a judgment about the atmosphere and values of the home. We spoke with four people to hear their views on their care. However, some other people were not able to comment specifically about their care experiences, so 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 living with dementia. On the second day, one inspector spent time looking in more detail at records relating to people's care as well as audits and records in relation to staff training and support.

We looked at all the information available to us prior to the inspection visits. These included notifications sent by the service, any safeguarding alerts and information sent to us from other sources such as healthcare professionals. A notification is information about important events which the service is required to tell us about by law.

During the two days of inspection we spoke with five relatives and friends or other visitors, and 16 staff. This included care staff, chef, domestic staff, manager, nurses and the administrator. We provided feedback after each inspection day to the manager and clinical director.

We looked at six care plans and daily records relating to the care and support people received. We also used pathway tracking, which meant we met with people and then looked at their care records. We looked at

three recruitment files, medication administration records, staff rotas and menu plans. We also looked at audit records relating to how the service maintained equipment and the building.

Following the inspection we asked for feedback from three health care professionals to gain their views about the service. We received feedback from all three.

Requires Improvement

Is the service safe?

Our findings

When we last inspected in November 2016, we found improvements were needed to ensure the environment was safe. This included poorly lit communal areas. We saw several bulbs were not working in the upstairs communal areas. This resulted in patchy lighting which was not suitable for people living with dementia and sight impairment. We also found one lounge area smelt malodourous, due to a carpet needing to be replaced. These areas had been addressed.

Bideford lounge had a new carpet which had made the room a more pleasant space to be in. Lighting appeared good in all communal areas. However, there were still areas which needed to be addressed. For example lounge chairs in Williamson house smelt strongly of urine and were in need of being deep cleaned or replaced. Two newly created bedrooms in Bideford house were in use but there were no radiator covers to help reduce the risk of people burning themselves. Some bedrooms had star locks fitted. These are locks which have a simple key to lock but could mean people may be locked in their rooms with no ability to unlock their door. We were assured these were old locks and were not in use. Following the inspection, within 24 hours the radiators identified had been covered and all star locks removed. The provider sent us photographic evidence of this work being completed.

The corridor between Bideford and Chichester had been extended out by means of knocking down some smaller rooms off the corridor. This had allowed the service to develop an alcove with further seating for people to use. This had also reduced the amount of incidents in this area. Previously this had been a narrow corridor area which created a bottleneck and meant people were sometimes having to negotiate their way around. Audits of accident and incident reports showed a reduction in incidents since this additional space had been created. This structural work had impacted in a really positive way and enhanced the living environment. One relative said ''The improvements in the corridor and the creation of more lounge space is really good and I can see it has helped reduce the incidents between people living here.'' Written feedback from another relative spoke about being ''pleased and impressed to see that there had been many improvements to the home. The decoration is clean and the toilet area is considerably improved. There was a much calmer atmosphere and there seemed to be staff available in every area.''

People were unable to give us a view about whether they felt safe, however our observations showed people appeared relaxed and moved around the units they resided in. One relative said ''I think (name) is safer here. The staff are pretty good.''

There were sufficient staff with the right skills and experience to meet the needs of people throughout the day and night. However the deployment of staff and their oversight into managing lunchtimes meant people were at potential risk. We observed one person waiting for their lunchtime meal for over 20 minutes. They could see other people were eating around them and at one point took food from another person's plate. We asked staff to make sure the person got their meal. Whilst they were preparing this, the person took another person's drink and began to drink from the beaker. They then struggled to swallow the fluid and we

again asked staff to intervene. The person was at risk of choking and had been assessed as needing fork mashable food and fluids which were thickened to a particular consistency. We fed this back to the manager and providers at the time of the inspection and was given assurances that they would give one staff member key responsibility to oversee the lunchtimes and any other meals and drink times in each area to prevent any further risks to people.

During our inspection we checked the way medicines were looked after and administered to people. There were policies in place to enable people to look after and take their own medicines if it was safe for them to do so. There was one person doing this at the time of the inspection. Staff were removing the doses from the labelled packs each day and putting them into compartments in a dosette box, to help this person take their medicines themselves. However there were no records to show who had prepared these doses each day, and we were told there were no risk assessments or documentation about this in this person's care plan.

Medicines were stored in locked rooms and trolleys. However one of the refrigerators was not locked and was in an office that could be accessed by other staff who were not authorised to look after medicines. There were no records to show whether the refrigerators had been monitored to ensure that the medicines in them were being kept at suitable temperatures. The thermometers in both refrigerators showed a suitable temperature at the time of the inspection. However both showed maximum temperatures above the recommended range for storing medicines, and one showed one below the minimum. This meant it was not possible to know whether the medicines would be safe or effective for people.

Some people were given their medicines covertly (without their knowledge). There were records that showed their mental capacity had been assessed and a decision had been made and recorded that it was in their best interests to receive their medicines in this way. The home's medicines policy required that this be reviewed every month, but the two people's records that we saw had not been reviewed for three, and seven months. The GP had been involved in this initial decision and family members had been consulted where appropriate. However, there was no record that the pharmacist had been involved in checking that the medicines were suitable to be crushed or mixed with food, which was not in accordance with the home's medicines policy. This meant that it was not possible to be sure that the medicines were safe or effective when given in this way.

We checked 13 people's medicines administration record charts (MAR charts). Charts were completed when medicines were given, however there were some gaps where it hadn't been recorded what doses had been given. Most of these doses appeared to have been removed from the blister packs that they were supplied in, but the records had not been signed. Therefore it was not possible to be sure whether they had been given, or the dose omitted for some reason. There were some variable doses, where one or two tablets or capsules had been prescribed and it had not always been recorded how many doses had been given. Most MAR charts were printed by the supplying pharmacy. However there were a few handwritten entries that had not been checked and signed by a second member of staff, which would be good practice and was required according to the home's medicines policy. Creams or other external items were recorded on the MAR charts but not signed when they were applied but ticked by care staff. Therefore it was difficult to determine which member of staff had applied the preparation.

We asked to see any recent medicines audits by the home, but we were told these had not been completed recently, and that at the end of each month the MAR charts were filed away without being checked or audited. Auditing medicines management and MAR charts regularly would have helped to pick up some of these issues which we found at this inspection. The supplying pharmacy came once or twice a year to do an

advisory visit, and they were visiting the home on the day of the inspection to complete this. Since the inspection we have been told there were medicine audits completed in June 2016, but not as frequently as required.

This is a breach of Regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

We watched a few medicines being given by one of the nurses at lunchtime and saw that these were given in a safe way. People were asked if they needed any 'when required' medicines such as pain relief. There were clear protocols for these 'when required' medicines written for each person, which provided guidance for staff to make sure people received their medicines in the way prescribed for them, and when it was appropriate.

There were suitable arrangements for storing and recording medicines needing extra security. There were suitable arrangements for the destruction of medicines and appropriate records were kept. There were policies and procedures in place to guide staff, and these were currently being updated. Two nurses were taking on the lead for medicine management and were working on this during the inspection process.

Care and support was being delivered by a staff group who had the right skills and training. There were sufficient numbers of staff on each shift to ensure people's needs were being met in a timely and responsive way. Each house had at least two to three staff available each shift. In addition there was always one trained nurse and on some days two. Care and nursing staff were supported by a team of housekeeping and maintenance staff as well as chefs and kitchen staff. Staff reported there were sufficient numbers of staff each shift unless there was short notice of staff sickness. Relatives said they had noticed an increase in staffing numbers and were confident people's needs were being met in a timely way.

Staff understood the types of abuse that could occur and what they should do report any concerns. Staff had received training in understanding abuse and the manager had been proactive in working with the local safeguarding team when they had asked her to do so. There was a good audit trail to show how any concerns about possible abuse had been investigated and followed up. One relative said following the inspection, that investigations into their concerns had improved in recent times and they were satisfied with the managers response to a recent issue they had raised.

Where risks had been identified, these had been assessed and measures put in place to reduce the risk occurring. Risk assessments were in place for falls, pressure damage, and poor nutritional intake. These were reviewed monthly by the nurse team and any actions to reduce risks were also reviewed. Where people were unable to use a call bell for example, but may be at risk of falling in their rooms, pressure pads were used to alert staff the person was moving, so they could check their safety quickly. Since the last inspection everyone has an updated emergency personal evacuation plan in case of a fire.

Staff recruitment files showed checks were completed in line with regulations to ensure new staff were of good character and suitable to work with vulnerable adults. New staff were required to complete an application form and any gaps in employment were checked with them at interview. Their last employer was asked for a reference and checks were made to ensure potential new staff did not have a criminal record which would preclude them from working with vulnerable people.

Good

Is the service effective?

Our findings

When we inspected in November 2016, staff were not always able to provide effective care because their induction, training and support had not always helped them to be effective. This in part was due to the fact the service had taken on a large number of new staff, some of whom were new to care. Newer staff had described a variable approach to their induction process, some describing a two day comprehensive induction with shifts shadowing a more experienced member of staff. Others had described a shorter induction and none were aware of being asked to complete the Care Certificate, which is a national induction process following all key areas of care work. Similarly staff described variable accounts of whether they had ongoing support and supervision to discuss their role and plan for their ongoing learning. At this inspection it was clear the service had worked hard to ensure staff had the right induction and training to support new and existing workers to gain the right skills. They had worked on an induction programme which followed the care certificate and had tasked one member of staff to ensure every staff member had completed this by a specified date in mid February. One staff member said ''Since the last inspection they (the providers) have taken on board that induction and training needed to improve. We are now all working through the induction book, more training has been booked and organised and supervisions are now in place.''

Most training was accessed via a web portal which staff could easily do from home or at work using the computers in each area. The administrator said ''For each care subject on eLearning, staff get paid for one hour. They are then required to complete a knowledge test and they are required to gain 100% otherwise they are required to complete it again.'' Areas of training covered included health and safety awareness, fire safety, infection control, first aid, safeguarding adults, mental capacity and dementia in care. The content of the dementia in care were discussed as this was something staff had asked the local care home's team for training in the past. The course covered types of dementia, communication, diet and nutrition in dementia care, meaningful activities and person centred approach. In addition to this basic knowledge, key staff had also embarked on the providers own year-long training course to embed their household model approach.

The management team had in place an innovative workforce development plan. Staff members understand the underlying philosophy of this model and demonstrated that they were meeting the needs of the people they were caring for. Staff who had attended this training described it as ''Inspiring and brilliant.'' Another staff member said ''best training I have ever done, I only wish every staff member could be doing it, but those of us currently undertaking the course have the responsibility to share our training and learning with the rest of the team.'' Feedback from one mental health worker about staff knowledge and training in Tarka house said ''Exceptional knowledge of client/residents, exceptional compassion and interest in residents and in expanding their own knowledge and training.''

Staff understood how to support people who were at different stages of their dementia. The household model was working well to promote people's well-being and help staff develop their skills further. For example two staff who worked with people in the later stages of dementia had begun specialist training in best practice for end of life care. This was being completed in affiliation with the local hospice.

People were supported to have their needs met effectively by a staff team who knew their needs, preferences and wishes. Whilst most people were unable to give an informed view, our observations showed staff worked well with people. Staff showed a high level of understanding people's needs and wishes. In discussion, staff were able to describe what was important to individuals and how they worked in a way to ensure these were honoured. For example one person was resistive to personal care interventions. Staff managed the potential for distress by offering the person their favourite croissants and ice-cream. Staff members were keen to explain the ways in which they managed people if they became distressed or angry. Safe-hold training was given and staff worked towards providing the least restrictive measures when managing difficult behaviours. A 'house leader' said "Staff here know the ways to calm people down, if (name of person) gets physical to staff or residents other staff divert him by mirroring, offering games he likes, in a few minutes he will settle". Several other staff members told us "we rarely have to use restraint we use distraction techniques instead".

At the previous inspection we had received some information about bedrooms not being kept warm enough. We checked some of the bedrooms and found they were warm and temperatures were being kept under review and monitored to ensure they remained at a suitable temperature

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

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA , and whether any conditions on authorisations to deprive a person of their liberty were being met.

The service acted in a way which ensured people's human rights were upheld. This included ensuring they worked in a way which encompassed the principles of the MCA

The manager had made appropriate applications to safeguard people's rights and work in the least restrictive way. Staff were mostly aware of who had such safeguards in place and why. Mental capacity assessments were decision specific and where people lacked capacity best interest meetings were held. This was to ensure best interest decisions included people who were relevant to the person such as their relative, GP and community nurse.

Staff understood the principles of ensuring people were given choices and where possible people' consent was gained. For example when providing personal care, staff were mindful if this caused people distress and worked as a team to find the best approach. Sometimes this meant leaving the person and trying again later, or as described above using their knowledge of what the person liked, to distract them. All staff demonstrated a clear understanding of their responsibility to gain consent from people before providing support. One staff member said "We have to be very thorough, to make sure from the person that it is OK before we do anything for them." Another staff member said ''We make sure people understand and give

them choices, if they refuse we walk away and come back later."

People were supported to eat and drink to ensure they maintained good health. The chef said their mealtime arrangements were flexible offering a range of cooked breakfasts throughout the morning. The main meal of the day was served at lunchtime but the chef said they were able to provide other light options if people preferred to eat their main meal later in the day. There were also snacks and drinks available throughout the day and evening. The chef said ''I always ensure there are plenty of sandwiches made up for people if they want something later in the evening. We have homemade cake everyday as well as fresh fruit, biscuits and crisps for people to have whenever they wish." We saw one person being assisted to have two large platefuls of cooked breakfast in the morning. Another person was offered a variety of options but settled on a jam sandwich which staff said was their favourite.

Some people had been referred to their GP and had been prescribed fortified drink supplements to help maintain their weight. Staff talked about the optimum moments, encouraging people when they could to eat and drink. For example some people ate well during the earlier part of the day and others ate more during the evening so food was always made available to suit individual requests and ensure good food and fluid intake was maintained.

Care records showed how people's health care needs were closely monitored and where needed healthcare professionals were called for advice and support. Healthcare professionals were consulted on a regular basis. For example Community Psychiatric Nurses (CPN) were asked to review people and support staff in developing the right strategies to reduce their anxieties and distress. The GP visited weekly and the manager said they were hoping this would in future include the input from a CPN. People were able to see their GP more frequently if required.

Good

Is the service caring?

Our findings

There were strong and caring relationships between staff and people who lived at the service. Throughout the day we saw many examples of staff offering people support, encouragement and compassion. During a music session one person was observed to be very distressed and crying. A staff member sat quietly offering soothing words, holding their hand and cuddling them. They then got some bubbles and this acted as a distraction for the person who was seen enjoying having a go at blowing the bubbles. Another person became disoriented and began urinating on the floor, the staff member guided them away to help maintain their dignity. They talked with the person in a calming way whilst another staff member cleared up. We saw one person was being assisted to have their hair brushed and when they said their head felt itchy the staff member gave them a head massage.

There was lots of laughter and fun observed throughout the day. Staff were sensitive to people's moods and knew how to use humour to encourage people. For example we saw one staff member dancing with people to encourage them to go to the dining room for lunch. One team lead said that staff were working hard to provide a homely environment for people "it was quite institutionalised when I started working here, now we have introduced tea and coffee pots on the tables at breakfast time and plan to introduce serving dishes in order that people can be encouraged to serve themselves." Staff understood the importance of ensuring meals times were social and an opportunity for people to engage with each other and with staff

On Tarka Unit staff offered people the opportunity to have their feet soaked and massaged twice a week. Staff understood the importance of touch being an essential part of people's emotional well-being. We observed many examples of caring and compassionate interactions between staff and people who lived at the service.

The service had received many compliments and actively sought feedback with feedback forms available in the reception area. Compliments which demonstrated the caring approach included ''Your empathy, consideration and love meant so much…which enabled us to go home knowing how well you cared for him.'' ''Thank you for all your kindness and caring you have given to mum and dad.'' One healthcare professional wrote ''The staff have been able to provide care and understanding which has really helped(name of person)''

Staff understood the importance of offering people choice and respecting people's wishes. This was sometimes complex because not everyone could articulate their choices and wishes in words. Staff were skilled at understanding people's non-verbal communication. For example, we saw one staff member observe the changes in someone's facial expression and acted to talk to the person about whether they were comfortable and could they get them a drink or something to eat.

Staff understood how to work in a way which ensured people's dignity, privacy and respect. Staff gave examples of how they did this in their everyday work. For example always ensuring personal care was provided to people in the rooms or bathrooms. Staff knocked on bedrooms doors before entering. When a staff member saw one person looked unkempt and had food down their clothes, they discreetly asked them

if they wanted to go and change into other clothes. They linked arms with the person and offered them reassurance.

Good

Is the service responsive?

Our findings

The service was responsive to people's needs because people's care and support was well planned and delivered in a way the person wished. One healthcare professional had written in their feedback that she was really pleased that the service had allowed the person to bring their pet dog. They felt they had settled really well and said ''Whatever you are doing to support (them) carry on! It is always a pleasure as a professional to see a success story.'' A visiting paramedic wrote the following feedback to the service ''Full handover with paperwork ten out of ten, very helpful and staff did as much as they can, outstanding from start to finish.'' This was in relation to the staff response to an emergency medical situation. A specialist nurse assessor was also impressed with the responsiveness of the service saying ''Person seems to have settled in well and is well managed, previously been in a non- residential environment and had huge challenging behaviours which have now gone.''

Relatives said staff were responsive to people's needs. One said " (name of person) has a floor alarm mat, they (staff) are getting better and better, I have noticed the difference" Another relative spoke about staff being more responsive to their requests and to their relative's needs ''We have been very concerned in the past about the heating in bedrooms, they have provided an extra source of heat for my (relative's) bedroom which is much better.''

Care plans demonstrated a person centred approach and provided evidence that staff have a comprehensive and holistic understanding and knowledge of people's needs. Registered Nurses had the responsibility of regularly reviewing and updating care plans. There was a section named "All About Me". This provided an insight into people's lives before admission. This information was currently being used to update the individual recreational needs of people. For example there were plans to develop a vegetable garden as it has been identified that several people are from farming/rural backgrounds.

Where possible people using the service were involved in decisions about their care, treatment and support. For example, one person, on admission required the assistance from three people to provide for their personal hygiene requirements. Staff said that by involving the person in their care and offering choices they were now able to manage their own care with prompts and support from one member of staff. A staff member, in post for four months, said "I like it here, I like the fact people can get up when they want, it's all about them."

Meaningful activities were in evidence throughout the day for most people. Staff members were observed interacting in a friendly, supportive and inclusive manner towards friends and family members. Daily records showed where people needed to be in their own room or chose to spend time in their bedroom, staff were checking on them at regular intervals to help avoid social isolation, although it was less clear whether access to meaningful activities was always available to such people as most activities took place in communal areas. One staff member told us they tried to ensure those people who needed bed rest had extra time to chat and socialise with them. There was a specific activities person but the staff team were working on having meaningful interactions and activities throughout the day, each day.

Staff members have created a Barber Shop environment and have found that by making shaving into an activity, male residents were more likely to enjoy having a shave. The ladies were offered manicures and foot spas were offered regularly to everyone. Staff said the foot spa was particularly popular and reduces levels of distress if people were agitated or upset.

There were regular opportunities for people, their families and friends to raise issues, concerns and compliments. Relatives said their views were being listened to and responded to. One relative said that when their relative had first come to the service they had not always been treated well, but that this had been quickly resolved. Another relative had kept CQC informed of all their complaints and concerns, and more recently had been impressed with the way the manager had investigated their concerns, which had been thorough and professional.

Visitors were encouraged to leave feedback with forms to complete in reception. The clinical director said they also wanted more active engagement with family and friends of people living at the service and had set up some meetings to talk through their new model and future developments within the service.

Requires Improvement

Is the service well-led?

Our findings

At the time of the inspection there was no registered manager in post, although we had been informed soon after the inspection that their application had been submitted to register with CQC. The manager had previously been the registered manager but earlier in the year made the decision to deregister as they felt they wanted a more hands on role. They now felt they were ready to take back the challenge of being the registered manager. Staff had confidence in the manager and said they were a good manager. One staff member said ''She is always ready to listen to us staff, she spends time on the floor, she knows what the job is and she is always helpful.''

Although systems had been set up to audit care and support, these had not picked on issues identified in this inspection. For example, there had no medicine audits completed in the last six months. Failure to complete these had led to issues not being identified such as lack of recording of room and fridge temperatures and issues with records relating to medicine management. Similarly lack of auditing of the environment meant rooms were signed off as ready for use when not all safety aspects had been considered. Two newly created bedrooms did not have radiator covers fitted but were in use on the day of the inspection. Concerns about the environment had also been identified at the previous inspection.

This is a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Other audits had significantly improved the care and support for people. For example directors and clinical leads had been auditing care plans and risk assessments on a weekly basis to ensure people had good outcomes for nutrition and pressure care. This was being done remotely as care plans and daily records are completed electronically which allowed directors and key staff to access these without needing to be at the service. It was clear the audits and suggested improvements to care planning and the way risks were managed had impacted in a positive way with fewer incidents of pressure or wound care needs.

There was a willingness from the senior team and directors to learn from incident reports, concerns and complaints as well as wishing to work with CQC as the regulator to improve the service. For example an analysis of incident reports and a concern expressed by one relative led to the provider making some structural changes to the corridor upstairs which had been a bottle neck where people appeared to get more agitated with each other. They had created a more open space and another seating area for people to relax and enjoy.

The ethos of the service was to provide the right care and support to people at whatever stage of their dementia they were at. All staff members conducted themselves in a caring and professional manner. They were keen to demonstrate areas of good practice and were clearly proud of their achievements. Staff said the levels of communication were good and that the manager was "very hands on, approachable, very much for the new model".

A staff member said " (Directors) from Head Office visit monthly to check that all staff are O.K., they look

through care plans and are very thorough, it is really nice to have that support".
Whilst acknowledging that the unit system worked well one staff member said "we need to do meetings for the whole Home, separation is good but staff need to be reunited as a whole Heanton team". We saw that meeting had been held for different departments and for each house and that a whole home meeting was being planned. Staff members were familiar with whistle blowing policies and procedures and told us that they would not hesitate to report and put in writing any concerns that they had.

Whilst staff reported that generally they felt that the organisation encouraged an open and transparent culture one staff member told us "we could be doing more, we have improved so much but there is room for more, we need to bring the community in more, we tend to shy away from the public". A Registered Nurse said "we are not fully there yet, but people are much calmer, it's because people with the same level of need are together and they tend to understand each other. The transformation in this place in just over a year is amazing".

The management team had been looking for ways to be more inclusive and to involve the local community. They had a planned tea dance to be held in the local village hall. They had also had fete days and coffee mornings to welcome visitors and relatives.

There was clear evidence of partnership working with local GP's, community psychiatric nurses, health care assessors and commissioning teams. Feedback from healthcare professionals was positive and there was a sense that the service was on a continual improving programme. One healthcare professional said ''I really feel I can work with the team here to achieve the best outcomes for people.''

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations 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 will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People who use services and others were not protected against the risks associated with unsafe medicine management and risk of choking 12 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance People who use services and others were not protected against the risks associated with lack of systems to pick up on environmental issues and staff practice in relation to management of medicines