Good Care Matters in Care Homes
An Enter and View Report
Heanton Nursing Home

Date of visit: 15 August 2017
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Details of visit

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<th>Unannounced visit planned for Tuesday 15 August at 12:30pm</th>
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<tr>
<td>Visit completed by</td>
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<td>Heather Mills (Authorised Rep)</td>
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<td>CQC Rating</td>
<td>Requires Improvement¹ (as at May 2017)</td>
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Acknowledgements

Healthwatch Devon would like to thank the service provider, the people living in the home, visitors, and staff for their contribution to our Good Care Matters programme.

Disclaimer

Please note that this report relates to findings observed on the specific date set out above. Our report is not a representative portrayal of the experiences of all service users and staff, only an account of what was observed and contributed at the time.

¹ www.cqc.org.uk/sites/default/files/new_reports/INS2-3721257488.pdf
What is enter and view?

Part of the Healthwatch Devon programme is to carry out visits to care homes. This activity is an element of a wider project to find out what people think of our local care homes. Local Healthwatch representatives can carry out visits to health and social care services to find out how they are being run and make recommendations where there are areas for improvement. The Health and Social Care Act allows Local Healthwatch authorised representatives to observe service delivery and talk to service users, their families, and carers on premises such as hospitals, residential care homes, GP practices, dental surgeries, optometrists and pharmacies. Enter and View visits can happen if people tell us there is a problem with a service but, equally, they can occur when services have a good reputation - so we can learn about, and share, examples of what they do well from the perspective of people who experience the service first hand.

Healthwatch Enter and Views are not intended to specifically identify safeguarding issues. However, if safeguarding concerns arise during a visit they are reported in accordance with Healthwatch Devon safeguarding policies. If at any time an authorised representative observes anything that they feel uncomfortable about they will inform their lead who will inform the service manager, ending the visit.

In addition, if any member of staff wishes to raise a safeguarding issue about their employer they will be directed to the Care Quality Commission where they are protected by legislation if they raise a concern.

Purpose of the visit

- To explore with people who use services, what good care means to them
- Identify examples of good working practice
- To contribute to a short consumer guide for people seeking help with residential care in Devon
- Capture the experience of residents and relatives and any ideas they may have for change

Strategic drivers

- Aging population
- Care homes are a Local Healthwatch priority

Methodology

This was an unannounced Enter and View visit to support our Good Care Matters project. A proportion of the visit was observational, involving the authorised representatives walking around the public/communal areas and observing the surroundings to gain an understanding of how the home actually works and how the residents engaged with staff members and the facilities. There was a checklist prepared which was used during the visit. This was informed, in part, by concerns shared from a member of the public as well as the topic areas in our Good Care Matters project, which are Food, Medicines Management, Complaints, Quality Assurance and understanding of the Mental Capacity Act and Deprivation of Liberty Safeguarding.
Visit outline

On the day of our visit, the evidence we saw shows that in our view, the home was operating to a good standard of care.

Prior to the visit the Healthwatch team had a meeting to discuss the key points of observation and enquiry.

Based on past information the following bullet points were decided upon:
- Access to other services
- Activities: social, emotional, and spiritual
- Clothing
- Complaints process
- Contact with care workers and care managers
- Involvement including welcome and induction to residents and family
- Medicines management
- Staffing

If it was appropriate questions could be asked, and general observations made regarding these areas as well as the topic areas of our Good Care Matters project i.e. Food, Medicines Management, Complaints, Quality Assurance and understanding of the Mental Capacity Act and Deprivation of Liberty Safeguarding.

The home is situated in an elevated position overlooking Braunton Burrows surrounded by pretty gardens and across the road from the village church. The large property has a sunny position. The expansive views across the estuary are shared by the residents from the communal areas in the house and some bedrooms.

This was an unannounced visit so upon arrival we needed to tell the staff about the functions of Healthwatch and our remit. Following a telephone call with the senior management and owner, we were granted entry.

We were greeted by the Clinical Care Lead as the Registered Manager was at a meeting. As there were four visitors from Healthwatch, it was decided we would be less disruptive to the residents and the staff if we split into pairs, each pair doing a floor.

We explained our purpose and the duty manager gave us an overview of the layout and model of care that the home has recently adopted.
Results of the visit

Environment
The large house is bright and light inside and the entrance hall has information about activities that residents can enjoy, the CQC registration certificate, food and hygiene certificate, the complaints procedure, and a red pillar box to post suggestions for improvement into if required. The reception area did seem dimly lit which belied the light and airy atmosphere in the rest of the home. This area is due to be revamped as soon as the family members’ areas have been finished, resulting in a complete redecoration of the entire building - the ideas and colour scheme have already been finalised. There was plenty of information about the home available.

The sizeable garden outside we were told is used by the residents and there were seating areas with chairs.

The house is divided into two floors which are in the process of being upgraded when we visited. The residents move across corresponding levels as their assessments demonstrate the level of care they require. The main area of need is dementia and the home are registered to provide support to fifty two people with personal care and nursing needs. At the time of the visit there were forty six residents at the home.

The home is on two floors so following an initial briefing in the reception area we split up into pairs to look at the care being given in each area.

On the ground floor is a kitchenette area. These accessible facilities mean people can have a snack and a drink whenever they want. Although lunch had been served from the main kitchen, one person was still eating their lunch, at their own pace. The atmosphere was very calm and relaxed. Staff take their meals with residents and no uniforms are worn. Through the kitchenette is a lounge with bookshelves and dividers where people have the choice to sit alone, or in smaller groups. A few people were asleep in their chairs. One person spoken with, who was on a short break, said she was very happy there, and seemed relaxed and contented as the interviewer sat with her. Another person sat quietly in a chair in a reading corner, occupied in playing with a toy doll. The TV was on but not obtrusively so, as one might expect to pass the time after lunch at home.

The top floor is reached by a staircase; all external doors are secure. Once inside the houses, as each separate unit is referred to, the atmosphere is light and airy with windows open on a warm sunny day. The windows are large with good views and safety catches to prevent over-opening. The upper floor is in the process of major building works which the staff have been fully involved with in planning as have the residents. At the time of our visit, one end of the building was being painted and it was to the staff’s credit that this was managed so well for the residents, who appeared not to be anxious or upset by this activity.
An enter and view report: Heanton Nursing Home

Staff
On the ground floor in one house, we had a long chat with the Clinical Care Lead, who was clearly passionate about her job and very well informed about the new model of care (see below). She explained that knowing about people’s past and their likes, dislikes and previous routines gave great insight into their behaviour post onset of symptoms. So, somebody who was used to doing a lot of DIY was in the secure patio area, brushing the floor and banging on fence posts.

The House Lead on the top floor had only been in post for four months at the time of our visit, and was open about the high staff changeover that had taken place which was due to the home’s change in its model of care. As with the ground floor, the lead on this floor also had a good rapport with staff, family and visitors with whom we spoke. We were told there were six staff on duty and a housekeeper, of these, one is always a registered nurse.

The staff were very happy to talk to us and demonstrate all the positive changes that had been achieved. Staff we spoke to were pleased with the level of training being offered such as NVQ2 and End of Life Care. They acknowledged they were still learning from the implementation of the new model of care but all felt it was providing better support for the residents.

The House Lead said she took part in all staff interviews and there appeared to be a happy working team.

Model of Care
Heanton has developed a model called the Household Model of Care, with the environment divided into smaller houses to support group living according to the level of their dementia. Staff have been recruited who are dementia practitioners. Although still learning about the model of care and its implementation they were very enthusiastic about how the people are responding to the new model. The model of care is adapted from an American model propounded by Steven Shields, directed by Eve Carder. You can watch a short video here [www.evolvecaregroup.com](http://www.evolvecaregroup.com)

The home is split into houses. People who live in the houses are referred by staff to as family members rather than residents. For ease of reading this report, however, we have referred to family members as residents in brackets.

Family members (residents) are individually dynamically assessed to ensure a compatible mix. This approach reduces conflict and distress, i.e. people with repetitive behaviours are grouped...
An enter and view report: Heanton Nursing Home

together; those with complex needs are grouped together. The type of care given has, according to the staff and relatives we spoke to, made a visible, rapid and positive impact on the family members (residents)’ dispositions.

All staff we spoke to were very knowledgeable about dementia and talked at length about the model change. A recurring theme was about the history of the home suffering from a bad reputation and that the frustration this causes the staff team. Even though changes had been made to improve the service, some staff had left because they did not agree with the new way of doing things; this critical attitude appears to have made an impact on the current staff we spoke to, who are proud of the work they are doing. A less regimented, more personalised approach takes time to put in place and the staff are to be commended for their dedication. Successful implementation of models of this type requires a whole organisational change.

In the formal response to this observation, the Clinical Care Lead told us:

“The staff turnover was predicted during the course of the culture change programme - staff who disagree with the model of care have moved on, interview process is now based around feelings and emotional intelligence to aim to employ staff who are right for Heanton and who have the love and compassion needed to give to the people that live there. Our induction programme has been completely revamped and is now very robust and we are currently trialling it - we will be getting feedback from new employees and watching how our retention is with this new approach.”

Staff are very enthusiastic about their jobs and demonstrated detailed knowledge about the family members (residents) they worked with. The person-centred approach caters for personal differences within the house. Staff carry out care alongside people and respond to their direct needs before practical tasks. For example, individuals get up in the morning and go to bed when they like (there is no regime), and activities are provided or enabled for people according to their personal likes and emotional needs. It is this change that appears to have posed a challenge for some people visiting the home and some staff. Perhaps staff could be provided with extra support in explaining, to relatives, the way in which Heanton provides care, particularly the differences that relatives may see when Heanton is compared to a “traditional” nursing home.

Activities
Activities were referred to as meaningful occupation and designed to be significant for the person performing them. So, whilst we saw what could be construed by some as meaningless repetitive behaviours, this was in fact a response to the person’s individual needs, for example, an ex-carpet fitter was measuring the floor and a keen knitter was transformed when she was given some wool and needles.

There is an Activities Organiser, but the staff member was on leave when we visited. We were told that family members (residents) are taken out to Tea Dances, there is gardening, the local vicar visits for those who take communion. A minibus is hired for outings, hairdressing and chiropody. The staff have good relationships with professionals and the local community. There is also a Newsletter (see appendix two) put onto the home’s Facebook page to help keep relatives informed about what is happening at Heanton.
**Rooms**

On the upper floor we were taken into one empty room to look at the equipment and the size of the accommodation. It was a light airy room with windows overlooking the garden and estuary, it was due to be redecorated and new curtains or blind fitted. The bed had a pressure mattress on it and there was a mobile hoist. The room could have been less cluttered and easier to work in if a ceiling track hoist was fitted, however the age and nature of the building prevents this from being installed. It was also subsequently explained to us that the advantage of mobile hoists was greater flexibility in room allocation to clinical need, as ceiling tracked hoists limits who can use the rooms. Electrically operated beds are in use including air pressure mattresses. These mattresses require air pressure calculation by the person’s weight, this is recorded on the individual’s care plan, the calculations may be recorded either weekly or monthly depending on the recipient’s assessment. The size of the bedrooms does not enable en-suite facilities to be provided, therefore commodes are used at night. The bed linen was very good quality.

All residents’ personal reports and care plans are held electronically, including food and fluids although a paper checklist is used to ensure everyone has had all courses offered to them. Another room we visited appeared to be a short stay room as it was smaller, but as there were two visitors as well it was difficult to judge it accurately. The family members (residents) seemed to have a good relationship with the staff and visitors joined in the banter with the staff team quite happily.

The communal rooms were bright and cheerful but were waiting to be redecorated in more soothing colours. We were told that the family members (residents) had been involved in this exercise. Floors are also to be upgraded so there will be some quite major works to be carried out in the next few months (Autumn 2017).

The House Lead has introduced fidget boxes in the corridors and stencils on bedroom doors to help residents to find their room. She hopes to have boxes outside the rooms fixed to the wall with a little bit of information about the person whose room it is and to show their interests and preferences.
General Observations

- **Residents, service users or clients:** Staff members told us that the people who used the home were not referred to as residents, service users or clients. They were referred to as family members as the nursing home was a home and that they wanted to create a family community in which to live. This was evidenced by staff eating their meals with the family members. Family members (residents) are treated with respect and dignity by staff and in a very relaxed and person-centred manner. There is a vibrant enthusiasm from staff about the new house model based around the stages of dementia.

- **Complaints procedure:** In the reception area there is a post box encouraging compliments, suggestions, and grumbles and additional guidance to complaints is available on the notice board.

- **Quality Assurance:** A variety of activities take place in the home although we weren’t sure how relatives’ views or suggestions were responded to. In the formal response given by the provider we were informed that all feedback is recorded and acted upon by staff, so we would recommend that perhaps some examples of this could be displayed in the reception area for visitors to see.

- **Activities:** Family members (residents) are encouraged to follow their own personal interests such as sweeping, cleaning, and walking. Lots of literature publicising structured, organised activities is available in the home. Evidence of lots of prompts for unstructured ‘meaningful occupation’ such as books, knitting, arts materials.

- **Environment:** The home is currently part way through a decoration programme. What has been completed is to a high standard. It is decorated in a tasteful and modern way with use of colour palettes that you would use in your own home. It doesn’t look institutional. Modern kitchenettes have been fitted which family members (residents) can use at any time to fix themselves a drink or a snack. The communal areas are extremely spacious and there are lovely well-kept grounds and outside space for people to use.

- **Medicine management:** No medicine trolley is taken into the public areas, according to privacy and dignity. To help keep people safe medicines are issued on a one-to-one basis by a registered nurse. This role is very time consuming but is a safe practice for both staff and residents. No home remedies are kept in residents’ rooms, this is due to the medical conditions of family members (residents) and therefore would not be a safe practice. Due to the level of capacity and conditions the Registered Nurse is responsible for discussing with the GPs and Pharmacist any changes in medication that may be necessary.

- **Food:** Late lunch taken by residents was observed during our visit, residents are helped/fed at meal times by the staff, drinks are available freely, nibbles are available throughout the day in both the sitting room and at the dining tables. We found on discussion with staff, breakfast offers cereals and a choice of cooked breakfast each day, residents may dip in and out of this meal during the morning. Lunch is a choice of two
An enter and view report: Heanton Nursing Home

meals plus special diets, Complan is also added as required, residents are assessed for swallowing and meals are made accordingly. For afternoon tea we saw a variety of homemade finger size cakes that residents enjoyed, evening supper includes soup plus a cooked meal at the residents’ request. All dietary needs are recorded on a paper document. Coloured crockery is used as people with dementia conditions can often find it hard to see white.

- **Infection control**: Each floor employs domestic help, cleanliness sits as a high priority, spillages are cleared promptly, all floors are washed down daily, chemicals are locked away. We observed the cleanliness of the shower room and the post cleaning following individuals taken to the toilet by the care staff.

- **Personal care**: Each resident has a care plan, which is updated regularly. The process was explained to us. Plans take into consideration people’s mobility, skin care, personal care (teeth, feet, bathing, hair washing, bowel movement). Dietary needs, particularly are discussed with relatives. The home prides themselves on skin care as they do not have any individual who has skin sores. All family members (residents) were in clean clothes and looked like they had good personal care. One resident was spotted with their name written on their shoes. A family member (resident) reported that he had soiled himself to a member of staff. This was dealt with sensitively and immediately. The Home employs their own laundry staff, all laundry is carried out on site, most of the residents clothing is named to try and eliminate mistakes.

- **Services and appointments**: Arrangements are made for any services individuals require, hearing aid batteries, optician, chiropody, dentist, medical care etc. If appointments are made for outside the Home staff will escort the individual to the appropriate service.

- **End of life care**: staff showed emotion when discussing the procedure that they carry out when a resident passes away. They also discussed the end of life training programmes available.

- **Staff training**: each member of staff has the opportunity for a personalised training programme. Feedback about how other staff who didn’t get on with the organisational and cultural change had now left the home. The staff we encountered were extremely positive about the changes and reported positive impact on the people that lived there.
Conversations with visitors

A daughter was sat with her mother and in conversation, we found that she was very relieved that her mother was, at last, getting the right care. She reported a marked improvement in her mother’s demeanour. Prior to her mother’s admission to Heanton, there had been a long period of crisis. The daughter could not fault the staff nor the care programme and spoke very highly of the quality of the service. She was, however, very critical of the attitude of a care manager from the local authority, who had told her that she couldn’t receive any help “until she was broken”. This does not seem to be a fair use of the Care Act, the interviewer briefly explained her rights to a proper needs assessment and gave her Healthwatch Devon contact details for further advice and information if needed. She said she had eventually got an assessment, but was grateful for the information.

A relative reported that their spouse had lived in the home for over 3 years and they had seen a lot of changes during this time. When asked about these changes they said that “lots of really good staff had left and there was just carers now”. The relative was asked if they were happy with the service and they said “so so, it has its ups and downs”. We asked if they knew what to do if they had a complaint and they said that they didn’t feel listened to. They went on to say that the home wanted to move their spouse to another part of the home but they didn’t understand why when their spouse was really comfortable and settled where they were.

The interviewer asked about access to health services at the home but the spouse was not aware of any services coming to the home. The relatively recent change in the model of care appears to represent a challenge not only to staff but also to relatives of long term residents who are used to the old way of doing things. It’s possible that they may need more support in understanding the reasons for the change and see the benefits. When we shared this view with the provider it was explained to us that the staff had observed that the family member needed to move due to fluctuating need. Despite being involved in care reviews and the change in needs being explained, the relative didn’t share the same view. Although the family member appeared settled and comfortable this was not always the case from the provider’s experience and observations. They had freshly decorated a room to help ease the transition. This difference of opinion may have contributed to the feeling of not being listened to and we hope the provider has been able to resolve the situation with the relative.

With regard to health services, there are purchasable options which had been raised with, but not pursued by, the relative. We did see local authority workers coming in and out of the home during our visit. And of course, medication and nursing care is provided by the home in partnership with GP surgeries and pharmacists.
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Recommendations

1. Review information that is given to families about the model of care used at Heanton. The website\(^2\) refers to dementia as a type of care, however, it was difficult to find specific information about this, unless you know a lot about dementia care.

2. If possible, prior to admission, relatives and care partners need clear explanations about the model of care offered. With information about how it might seem different to that which they have previously experienced. Although a brochure is available, a version of this does not appear to be online, although a copy can be requested by submitting an online form\(^3\).

3. During our visit, we spoke to somebody who did not appear satisfied with some aspects of the service. In response to this we were informed by the provider that despite at least 8 meetings with the Director to discuss the differences of opinion and clarify understanding, there was no consensus between them and staff about an internal move. This issue about moving between houses was raised with us by a different person prior to our visit. We hope that these situations can be resolved, and we recognise that despite these differences staff strive to provide the highest quality care. Whilst we understand that people with negative experiences may be in the minority, and there will always be a challenge in dealing with differences, we want to support the provider to help relatives understand why things might change, particularly for people living with dementia and similar conditions. To this end, we would recommend a continuing focus on the benefits of a move and a clear pathway for family members.

4. Relatives and visitors need to know about the pathway through the home as their relative or friend’s condition progresses.

5. External communication on the organisational and cultural changes could be improved. Professionals including hospital staff need to be better informed about the model of care and they need to ensure that relatives and care partners are aware of these circumstances if a placement is made as a response to an emergency.

6. Some examples of feedback and how it has been acted on could be displayed in the reception area for visitors to see.

Conclusion

Above this paragraph are our recommendations. To those, and any observations in this report, we invited comment from the provider about what we found on our visit. We can now place in context the feedback we received from the public previously and we see that unsurprisingly, the challenge in implementing a new model of care has not always gone smoothly. Given that the staff, however, were not given notice we were arriving, we feel that we found a care home that was happy and really person-centred. We would like to thank the staff, family members (residents) and visitors who took the time to share their views with us.


\(^3\) [www.heantonnursinghome.com/brochure/](http://www.heantonnursinghome.com/brochure/)
Provider response to the report recommendations

As well as amendments to factual detail in this report the provider also responded as follows to our recommendations; we have made amendments accordingly. In respect of the service provider’s response to the comments regarding the person’s viewpoint we fully understand that one individual experience cannot represent the views of everybody, nevertheless that testimony provided some insight into the difficulties some people were facing adapting to what was to them the change of the “traditional” delivery model. The provider has also demonstrated the time taken to help resolve that person’s issues, which we fully commend.

“Point 1 and 4 - We take on board about how to communicate our model of care. Some progress has been made already - we have appointed a ‘Relationships Manager’. Part of this person’s role is to educate outside professionals/organisations about the household model and she has already met with quite a few. She is also working with the local community groups and we have recently held a function for a community group at the home. There are many care managers/CPNs etc. that have visited the home and had a tour, many of them are referring people to us now and believe in the outstanding outcomes that we are achieving. The company now has a robust Marketing Department who are also looking at ways to get the message out there about what we do. The amount of outside professionals that are now engaging with the home and particularly referring into us is evidence that what we are doing is outstanding practice - some care managers have stated that only Heanton would be appropriate for some individuals.

Points 2 and 3 - We plan further discussions about how to communicate with present and future relatives - when relatives come to view the home the model of care is clearly explained as we tour the home and I believe this is why more and more people are understanding what we do, the moves through the houses are explained at this point. It is also stated in the contracts that people may be moved due to clinical need at any given point. I think that points 2 and 3 should be removed as this appears to be purely based on 1 individuals account on the day and this is not a balanced viewpoint, was anyone else asked about this to balance this view? We have had several others move through the houses with no problems and the relatives have completely understood and agreed when approached.”

Paula Mascall, Clinical Lead
This report has been produced by Healthwatch Devon - the independent champion for health and social care in Devon. We would like to thank everyone who took the time to share their experiences.

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