

Heathcotes Care Limited

Heathcotes Wendover House

Inspection report

137 Wendover Road
Stoke Mandeville
Aylesbury
Buckinghamshire
HP22 5TF

Tel: 01296612598
Website: www.heathcotes.net

Date of inspection visit:
05 September 2018

Date of publication:
11 October 2018

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?

Good ●

Is the service well-led?

Requires Improvement ●

Summary of findings

Overall summary

This was an unannounced inspection which took place on 05 September 2018.

Heathcotes Wendover House is a care home (without nursing) which is registered to provide a service for up to seven people with learning disabilities. There were five people (including a person who was in hospital) living in the home on the day of the inspection. Some people had associated difficulties such as being on the autistic spectrum and needing support with behaviours.

People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided and both were looked at during this inspection.

Heathcotes Wendover House accommodates people in a large adapted building. Everyone had an en-suite bath or shower room. The service was run in line with the values that underpin the "registering the right support" and other best practice guidance. These values include choice, promotion of independence and inclusion. People with learning disabilities and autism can lead as ordinary a life as any citizen.

The service was registered on 08 August 2017 and this was the first inspection.

People were protected from abuse. Staff training in safeguarding people was provided and annual refreshers were planned to be provided. Staff fully understood their responsibilities with regard to people's safety and knew what action to take if they identified any concerns. The service identified health and safety, safe working practices and individual risks to people. All aspects of safety were considered and actions were taken to assist people to remain as safe as possible.

People were supported by high staffing ratios which enabled staff to meet people's specific needs, including any relating to diversity and/or special needs, safely. Recruitment systems made sure, that as far as possible, staff recruited were safe and suitable to work with people. People were supported to take their medicines, at the right times and in the right amounts by staff who were trained and competent to do so.

People were offered effective care by an appropriately trained staff team. They met people's diverse needs including their current and changing health and emotional well-being needs. The service worked with health and other professionals to ensure they offered individuals the best care they could.

People were assisted to have maximum choice and control of their lives and staff supported them in the least restrictive way possible. The policies and systems in the service supported this practice.

The staff team were caring, patient and committed to meeting people's complex needs with kindness and respect. They ensured they promoted people's privacy and dignity and communicated with them effectively.

The service was person centred and responsive to people's diverse, individualised needs and aspirations. Activity programmes met people's needs, preferences and choices and were further improving to become more varied and imaginative.

Care planning was individualised and regularly reviewed which ensured people's current needs were met and their equality and diversity was respected. The service was not always responsive to people's family and friends and did not always identify and respond appropriately to complaints.

The service had a registered manager who was registered on 27 July 2018. This was the fourth manager since registration which had contributed to some instability in the service. The quality of care the service provided was assessed, reviewed and was being improved as the service stabilised. The management team did not tolerate any form of discrimination relating to staff or people who live in the service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good ●

The service was safe.

People were protected by risk assessments which staff followed to make sure people were as safe as possible.

Medicines were given safely at the right times and in the right amounts.

People were kept as safe as possible from abuse or ill-treatment of any kind.

There were enough staff who had been recruited as safely as possible to offer people safe care.

Is the service effective?

Good ●

People were supported to make as many decisions for themselves, as possible. The service worked in people's best interests and the principles of the Mental Capacity Act 2005 were upheld.

People were helped to remain as healthy as possible. They were supported with any special needs with eating and drinking.

People were assisted by staff who were supported and taught how to offer good care.

Is the service caring?

Good ●

The service was caring.

The staff team supported people with kindness and respect.

People's needs were met in a sensitive and patient manner.

The staff team 'listened' carefully to what people were communicating to them.

Is the service responsive?

Good ●

The service was generally responsive.

People and their relatives and friends did not always know how to make a complaint, if they needed to. The service did not always understand when a complaint had been made and respond appropriately.

People were offered a service that responded to their individualised needs, in the way they preferred.

People's needs were regularly looked at and care plans were changed as necessary.

Is the service well-led?

The service was not consistently well-led.

The service had had four managers since registration. This had not been an ideal situation. The stability of the service and staff team was beginning to improve but was not embedded, as yet.

The provider, registered manager and staff team made sure they monitored the quality of the service and took action to improve things for people living in the service.

Requires Improvement ●

Heathcotes Wendover House

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.

The inspection was unannounced and took place on 05 September 2018. The inspection was completed by one inspector.

We used information the provider sent us in the Provider Information Return (PIR). This is information we require providers to send us to give us some key information about the service, what the service does well and improvements they plan to make.

We looked at all the information we have collected about the service. This included notifications the registered manager had sent us. A notification is information about important events which the service is required to tell us about by law.

We looked at paperwork for the five people who live in the service. This included support plans, daily notes and other documentation, such as medication records. In addition, we looked at records related to the running of the service. These included a sample of health and safety, quality assurance, staff recruitment and training records.

We spoke with one person who lives in the service, interacted by body language and facial expression with another and observed interactions between people and the care staff. We spoke with the covering manager, the area manager, a relative and seven members of the staff team. After the inspection we contacted three relatives, five staff members and three professionals. We did not receive any further information from the five staff or three professionals. Additionally, we sought information from the local safeguarding team.

Is the service safe?

Our findings

People were safe and were protected, as far as possible, from any form of abuse. Staff received safeguarding training and knew how to raise any concerns, as necessary. Staff were confident that the registered manager would take immediate action to ensure people's safety. People indicated they felt safe in the home and a family member told us they were confident their relative was safe. Nine concerns had been referred to the local authority by the service since the registration of the service. Those necessary were notified to the Care Quality Commission. Medicines administration and distressed behaviours were the general themes of the concerns. One referral was outstanding and eight had been dealt with appropriately by the service and closed by the local authority safeguarding team. Staff members said they felt, "Service Users are safe and well treated at Wendover, we care for them very well." Family members told us they felt people were safe. One relative commented, "I would know if they were not looking after [name] well from [their] general demeanour, body language and [their] usual happiness would diminish." Another said, "I have no concerns about the safety of [name]."

People, staff and visitors were kept as safe from harm as possible. The service had a detailed overall health and safety policy. Maintenance and safety checks were completed at the required intervals. For example, there were records of gas safety and electrical installation checks. There were robust fire safety procedures and records of fire safety equipment checks. A building certificate stating that the building work completed prior to the service opening was safe and satisfactory had been obtained. Health and safety and safe working practice risk assessments were in place. Examples included, a legionella risk assessment, an asbestos survey and an assessment for the use of display screen equipment.

The service had developed risk assessments and risk management plans for individuals. These were person-centred, detailed and informed staff how to care for people safely whilst allowing people as much independence as possible. They were entitled 'positive risk taking' and noted what the outcomes for the individual might be if risks were not taken. For example, not accessing the community or participating in some physical activities. Risk assessments included bicycle riding, in house activities, finances and walking without support.

A business continuity plan provided written instructions for staff to consult in an emergency. Each person had a personalised emergency and evacuation plan tailored to their particular needs and behaviours. A member of the management team provided 24 hours 'on call' for support for staff. People's safety was further considered because the service learned from any accidents or incidents. Detailed accident and incident reports were completed. The manager ensured any actions to minimise the risk of recurrence were taken and the staff team discussed and learnt from them.

The service was clean, hygienic and well presented on the day of the inspection. Staff followed infection control guidelines about laundry and disposal of waste materials. An environmental food hygiene check in August 2017 had resulted in the service receiving a 4 (good) rating.

People's finances were dealt with by the local authority or people's families. The service kept some personal

allowances for people. The cash the service held was protected by a variety of systems and their finances were checked regularly. An audit of all finances had been completed in January 2018 and no issues had been identified.

Care staff supported people with behaviours which may cause distress or harm to themselves or others. Behaviour plans were developed by the management team and other behavioural specialists, as necessary. Care staff were trained, by means of a nationally recognised system, in the use of techniques to reduce anxiety, distract and divert people from harmful or distressing behaviour. However, the service used physical interventions, as a last resort, to keep people safe. All physical interventions, including the use of medicines to help people with their behaviour control, was entered into the 'restrictive physical restraint book'. These described the restraint and cross referenced with the incident form. The staff team used this information to discuss what had happened and what they could do better if a similar incident occurred in the future. However, there was little detail about the actions taken by the staff prior to the use of the restraint. Never the less it was evident that behaviour programmes and plans were having a positive effect and distressing or harmful behaviours were reducing. For example, on person who was having several behavioural issues a week had successfully reduced them to one or two a month. The service, additionally, recognised when they were not able to meet people's needs and took the appropriate action.

People were given their medicines safely by two staff at least one of whom had been trained and their competency assessed by a senior staff member. The home administered medicines from original packaging as provided from the pharmacy. Medicines were checked against medicine administration record sheets (MAR) and signed in when delivered to the service. They were stock controlled by being counted and recorded twice a day. The MAR sheets were photocopied, one was signed by the staff member who was giving the medicines and the copy signed by the staff member who was witnessing the administration.

There were guidelines/protocols to identify when people should be given their medicines prescribed to be taken when needed (PRN). However, those PRN medicines given to support people to control their behaviours may need more detail or cross referencing to behaviour plans, to ensure they were given in a consistent way. Four medicine concerns had been reported since registration. Three referred to people not receiving their medicines at the correct time (because of behaviours or activities) and one was with regard to dosage during a person's admission phase. All issues were appropriately dealt with.

Staffing ratios were high to enable staff to meet people's complex and diverse, assessed needs. There were a minimum of five staff per shift during the day and two staff awake during the night. Day time staff provided a 1:1 ratio and some people had a 2:1 staffing ratio for safe access to the community. Staff told us there were enough staff to keep people safe. Staffing was flexible and the manager could make immediate changes, dependent on people's needs. For example, staffing was increased temporarily to support people with serious health or behavioural needs. Staffing had been an issue since registration, there had been a large number of leavers and the staff team was just beginning to stabilise. This had not impacted on the safety of people.

People were provided with care by staff who had been checked to ensure, as far as possible, they were suitable and safe to work with people. Recruitment processes included safety checks such as Disclosure and Barring Service (DBS). The DBS checks confirmed that employees did not have a criminal conviction that prevented them from working with people. Application forms were completed fully and references were requested and validated, as necessary.

Is the service effective?

Our findings

People were supported by an effective staff team who met people's individual identified needs. Detailed care plans provided staff with the necessary information to ensure they could offer people appropriate, up-to-date and relevant care and support. The relatives we contacted felt their family members were happy and generally well looked after.

People were supported to manage any health conditions effectively and remain as healthy as possible. Support plans covered all aspects of care including health and well-being. People had individual health action plans and hospital passports. The action plans contained information about all aspects of people's health such as GP appointments, medicine reviews and any necessary regular health and well-being checks. The hospital passport contained all the information that hospital staff would need such as communicating with the individual. Referrals were made to other health and well-being professionals such as GPs, district nurses and specialist consultants, as necessary. Any medical appointments or referrals were clearly recorded and followed up as necessary. Other professionals were used to provide specialist training in areas such as specialised feeding methods and behavioural support. A relative commented, "[Name] is always rushed off to the Doctors for the slightest thing that is wrong so I have no worries there."

People were encouraged to eat a healthy, well-balanced diet. However, some people did not follow healthy eating options and ate food of their choice. Any specific needs or risks related to nutrition or eating and drinking were included in support plans. Records relating to nutritional input were kept as necessary. People chose when and where to eat their meals and were appropriately supported by staff. Care staff completed the catering tasks but involved people as much as possible. They were encouraged to participate in choosing, purchasing and preparing food, as appropriate.

The service supported people with their rights under the Mental Capacity Act 2005. People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The 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 people of their liberty were being met. Applications had been made for the five people who live in the service. Some had been authorised by the local authority and others were awaiting completion of the process.

People were encouraged and supported to make decisions and choices of their own. Care plans included individual assessments for some areas of care to establish whether people had capacity to make specific decisions, when and how. These included finance, consent to care and aspects of daily living. Staff understood capacity and consent issues and acted in the best interests of people they supported. Best interests meetings were held, as necessary and records were kept of who was involved in the decision-making process. Examples included medical procedures and control of finances.

People benefitted from an appropriately trained staff team who were supported to understand people's

individual needs. Specialist training was provided as and when required to meet any specific or diverse needs. For example, specialist feeding techniques, autism and epilepsy. Three of the eleven staff had acquired a professional qualification. Staff members told us they had, "Very good" training opportunities which they were encouraged to take up. Some staff told us that the training they received increased their confidence and really improved the way they worked with people. They said this was particularly relevant when working with people with behaviours that could be distressing and/or harmful and with people with other types of special needs.

Many of the staff team were new to the service and to care. They told us that other staff were supportive and helped them to get to know the people who lived there very quickly. They completed an intensive induction before working as a team member and were pursuing the care certificate (a nationally recognised set of standards for care staff.) The registered manager and team leader competency assessed staff as part of the supervision process. Staff told us the registered manager was, "Very approachable and totally supportive." Another said that she had taken a few weeks to get to know but was now, "Always available, approachable and supportive on both a professional and personal level."

The service had been converted to a care home specifically to meet the needs of people who were going to be accommodated. The environment was suitable to meet the needs of the people who lived there. Bedrooms and en-suite facilities and were designed and organised to meet the specific needs of the individual. Ground floor accommodation was available to people who had mobility difficulties. Equipment was provided for people with any specific needs to ensure they could be as comfortable and independent as possible. Communal areas were spacious and well designed, including outside space. The service was well-equipped comfortable and homely. It reflected the preferences, needs and personalities of people.

Is the service caring?

Our findings

The staff team were committed to providing people with kind and caring support. Staff were respectful, sensitive and patient when interacting with people. They used skilful gentle persuasion to support people to complete tasks and 'listened' carefully to what people were saying or expressing both verbally and non-verbally. Staff interacted positively with people who were included in all conversations and involved in tasks being undertaken, as far as possible. Daily notes were written in a positive and respectful manner. A relative commented, "I have only ever seen all the staff being very kind and patient with [name] and the other residents."

Care plans ensured staff could support people who become upset or distressed. Staff used appropriate physical touch and voice tone to calm and re-assure people. People approached staff for re-assurance and comfort, on occasion. Relatives told us staff were kind.

The small number of people assisted staff to develop strong relationships with people which meant they knew their preferences and needs well. People were supported to maintain important relationships and make new ones, as appropriate. For example, people were assisted and encouraged to keep strong contacts and links with their families and friends. People's families visited regularly and were kept involved in their care, as appropriate. Families had varied feelings about how involved they were. For example, some felt they were fully involved in all aspects of people's care and others felt that the registered manager and staff did not always keep them up-to-date with what was going on. Staff told us they felt they had developed good relationships with families.

Some people could verbally communicate but most used individual methods of communication. Each person had a communication plan which described the ways they communicated and expressed themselves. These included what people's particular sounds and physical displays indicated. Some people used nationally recognised methods of communication which included pictures, symbols and signs. People communicated with staff and were comfortable in their presence. People and staff understood each other well.

People's privacy and dignity was respected and promoted. People were provided with en-suite facilities which included a shower or bath. All personal care was conducted in people's rooms. The communal bathroom was used only if people chose to use the bath. Doors were closed and curtains closed to preserve people's privacy and dignity. People who chose not to have net curtains were provided with special one-way glass, so that they could see out but others could not see in. People were assisted with personal care by staff of the same gender (exceptions could occur in emergencies.)

People were offered the opportunity to be involved in and comment on their home and the care they received via 'service user meetings'. Two had been held in 2018 and it was planned they would be more regular going forward. People were encouraged to be as involved as possible in the meetings. People and staff's diversity was viewed as a positive asset by the service.

People's diverse physical, emotional and spiritual needs were met by a staff team who were provided with the appropriate information to do so. Some staff were able to support people's specific needs as they had similar life experiences and an understanding of the impact of particular conditions on individuals. Individual support plans noted, for example people's religious beliefs and how they chose to pursue them, any family cultural beliefs and any lifestyle choices.

The staff and management team fully understood the importance of confidentiality. People's records were kept securely in a 'manned' or locked office and only shared with others as was necessary.

Is the service responsive?

Our findings

The service was responsive to people's varied needs. Staff responded quickly and appropriately to people during the inspection visit. They understood people's requests and needs, however they were displayed, and reacted in a timely and appropriate way. Staff intervened early to try to distract people from anxious and distressing behaviour. They followed the individual's positive behavioural plan to support people to control their behaviour. People and staff were protected from any form of discrimination by the registered manager and management team.

People were fully assessed prior to being admitted to the service. They completed visits and got to know people and staff before they decided whether they wished to live there or not. The assessment process was completed with relatives and other professionals, as appropriate. The registered manager and staff continued to assess people's needs after admission. The staff team were able to identify if and when they could not meet an individual's needs.

Reviews were held a minimum of 12 monthly and in response to people's changing needs, as often as necessary for the individual. Support plans showed that staff responded to people's changing needs. Care plans noted how others were involved in the care planning process, this included relatives. Some relatives told us they were involved in reviews and planning people's care. However, others told us they did not feel involved at all and said they had not seen people's plans of care or been involved in the review process.

People had personalised care plans which ensured care was tailored to meet their individual and diverse needs. Care plans included the elements called, "How you can support me", "What's important to me" and, "What's important to me for the future." Care plans described people, their personalities and goals and aspirations for the future, in detail. They additionally described the best ways for staff to respond to people and how people preferred their care to be delivered. People's preferences were often determined by their behaviour and body language after staff had supported them with daily routines or activities.

People had individual communication plans to ensure staff and people could communicate as effectively as possible. People's communication plans ensured they had access to the information they needed in a way that gave them the best chance to understand it. The service was complying with the Accessible Information Standard. The Accessible Information Standard is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given. Information was produced for people in user friendly formats such as an easy read version of the complaints procedure and daily activity board.

People were supported to use IT systems to aid their communication and enjoyment of life. For example, people had interactive televisions, personal hand-held computers, mobile phones and game consoles. Some People could access social media systems to keep in contact with friends and family.

People were encouraged to participate in individualised, flexible activities. Arrangements for activities were made with people and met people's individual needs, preferences and moods. These included community

presence, participating in daily activities, bowling and swimming. A person told us they enjoyed the activities and the craft work they were offered. Some people were provided with a specific number of hours to support a 2:1 staffing ratio to ensure they could participate safely in community activities. Staff told us that activities had not been very good but they were now improving and staff were becoming more creative and keen to access new activities for people. Additionally, activities were dependant on people's choices, moods and behaviour and could not always be completed, as planned. The reasons why activities had not occurred was not always well documented. Some relatives felt the 2:1 hours were not always best used and thought the activities programmes could be better organised and offer people a wider variety of meaningful activities. They added that they felt they were improving but still had, "A way to go."

The service had a robust complaints procedure which was produced in a service user friendly format, displayed in the office. The service had not received any formal complaints about the service, since registration. However, some relatives told us they had raised concerns about some aspects of the care which had not been dealt with. Examples were given but the concerns had not been identified as complaints by the service and there were no records available of the action taken to address the issues. Some relatives told us they were not aware of the service's formal complaints procedure.

We recommend that the service seek advice and guidance from a reputable source, about the management of and learning from complaints.

Is the service well-led?

Our findings

The management and leadership of the service has been unstable since registration. Since the service registered there had been three registered and one acting manager in post. Some relatives and staff told us they felt this had impacted on the quality of the service provided and the forming of positive relationships. The staff team had continually changed and approximately three staff were left from the original group. Some relatives felt this was detrimental to relationship building and offering consistent care. Some staff told us that the service had been, "A mess" and "taken a while to establish itself" but they said it was, "Now settling down."

The service was led by a manager who was appointed in April 2018 and registered with the Care Quality Commission on 27 July 2018. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Some relatives felt the registered manager was not approachable and her attitude towards them was not always respectful. Comments included, "She can be abrupt with relatives and staff" and, "She is not always supportive or responsive." Another said she did not always treat relatives with respect. However, other relatives expressed no concerns about the registered manager. One commented, "The manager and the staff always keep me updated about anything that is happening with [name]." Every staff member we spoke with told us the registered manager was supportive and approachable. One staff member said they had taken a while to get to know her but now found her very easy to talk to and could discuss anything with her.

The service listened to and considered the views of people and the staff team but some relatives felt they were not always listened to. People's views and opinions were recorded at service user meetings, in daily notes and at reviews. Relatives were not included in any house meetings or social occasions held at the service. Some relatives felt this was an issue whereas others did not comment on it. The registered manager told us they were considering ways to improve relationships with relatives and met with anyone who was not happy. She felt that generally everyone involved in people's care worked together in their best interests.

People benefitted from a service that was regularly monitored and audited to ensure the quality of care being provided was maintained and improved where necessary. A variety of auditing and monitoring systems had been developed. For example, the organisation conducted monthly quality monitoring visits which were completed by a regional manager. These included the regional manager selecting random samples of care plans, staff supervision and appraisal notes and staff competency checks. Additionally, the regional manager completed SOFI observations (SOFI is a way of observing care to them understand the experience of people who could not talk with them.) The organisation had a specialised quality assurance team who completed further audits of the service. They produced a 'Home Audit Report' and these contributed to actions plans to be completed by the service.

Actions taken as a result of the various auditing tools and listening to people included, organising more

activities, reviewing and up-dating support plans and continuing to recruit permanent staff. Actions were ticked off and signed as they were completed (if they were not 'ongoing').

People's records were up-to-date and reflected their current individual needs. They informed staff how to meet people's needs according to their preferences and choices. Records relating to other aspects of the running of the home such as audit records and health and safety maintenance records were well-kept, up-to-date and easily accessible.

The service worked closely with community professionals and other organisation such as local authority care managers, behavioural specialists and the local G.P surgery.

The registered manager and staff team understood when statutory notifications had to be sent to the Care Quality Commission (CQC) and they were sent, when necessary, in the required timescales.