Havencare (South West) Limited

Botchill House

Inspection report

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Date of inspection visit:
30 November 2016

Date of publication:
21 December 2016

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?	Good

Summary of findings

Overall summary

The inspection took place on 30 November 2016 and was announced. This was to allow the registered manager time to prepare people for our visit as unexpected changes to routine and unfamiliar faces were difficult for some people to cope with. Botchill House provides care and accommodation for up to fifteen people with learning disabilities. On the day we visited ten people were living in the service. Everyone had been living at the service for several years and had moved in together from a nearby long stay hospital. Botchill House is part of the Havencare group which has other services in the region.

There was a registered manager in post. A registered manager is a person who has registered with the CQC 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. The registered manager was also a registered manager at another Havencare service. They were supported at Botchill House by a service manager who had daily oversight of the service.

The house, whilst only 1.5 miles from Dawlish, is in a very rural setting and is set in extensive grounds. There is a large orchard next to the property, areas for growing vegetables and a chicken coop. On our arrival we were greeted by some of the people who lived at Botchill House and the registered manager. A social story had been created about our arrival and this was displayed on several walls in shared areas of the building. Social stories are short descriptions of particular events. They are used to support people with a learning disability or autism to understand what to expect in a specific situation.

There was a sense of activity as we arrived and some people were getting ready to go out. We were directed to the office and for some time the door was kept open which enabled people and staff to come in and out and meet us when they were ready to do so. Later the door was closed to enable some of the more sensitive discussions to happen but we were told that this was different to usual and people were used the office door being open. It was clear the door being closed was not people's preference and it was good to experience their expectation that the office was open to all.

People's medicines were managed safely. Medicines were stored, given to people as prescribed and disposed of safely. Staff received appropriate training and understood the importance of safe administration and management of medicines. People were supported to maintain good health through regular access to health and social care professionals, such as GP's, dentists and speech and language therapists.

People's care records were detailed and personalised to meet individual needs. Staff understood people's needs and responded when needed. People were not able to be fully involved with their care plans, and plans were underway to develop a more user friendly version of support plans to give people greater ownership of them. People's preferences were sought and respected.

Risks were documented, monitored and managed well to ensure they remained safe. One person had recently been identified at being at increased risk to choking. The risk assessment had not been fully updated to reflect the change. Evidence to show staff had read new information contained in the communication book had not been signed as seen by all staff. Staff we spoke with were clear as to how to support the person safely and arrangements for input from other healthcare professionals were in place.

People lived full and active lives and were supported to access local areas and activities. Activities reflected people's interests and individual hobbies. People were given the choice of meals, snacks and drinks they enjoyed whilst maintaining a healthy diet. People, when possible were encouraged to help prepare meals and drinks.

People's needs in relation to their behaviour were clearly understood by the staff team and met in a positive way. Staff had a good understanding of people's communication styles and were able to support our conversations with people.

Staff had completed safeguarding training and had a good knowledge of what constituted abuse and how to report any concerns. Staff described what action they would take to protect people against harm and were confident any incidents or allegations of abuse would be fully investigated.

Staff and relatives were positive about the management of the service. There was a robust system of audits in place to help ensure the safe running of the service. These were carried out internally and by a representative from the Havencare senior management team.

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. Staff had a good understanding of how to recognise and report signs of abuse.

There were sufficient numbers of staff to support people according to their needs and preferences.

People received their medicines as prescribed. Medicines were managed safely and by staff who were trained and confident.

Is the service effective?

Good

The service was effective. People received support from staff who had the knowledge and training to carry out their role.

People could access health, social and medical support as needed.

People were supported to maintain a healthy and balanced diet.

Is the service caring?

Good

The service was caring. Staff were caring, kind and treated people with dignity and respect.

Peoples preferred communication styles were recognised and accepted.

People had formed positive caring relationships with the staff.

Is the service responsive?

Good

The service was responsive. People received personalised care.

Staff responded quickly and appropriately to people's individual needs.

People were supported to undertake activities and interests that were important to them. People made choices about their day to day lives.

Is the service well-led?

Good

The service was well led. There was a registered manager in post who was supported by a service manager.

There were systems in place to monitor the safety and quality of the service.

The provider had a clear set of visions and values which were communicated to the staff team.

Botchill 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 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 announced inspection was carried out on 30 November 2016 by one inspector and a specialist advisor. The specialist advisor had experience of working with people with a learning disability. We gave the service 48 hours' notice of the inspection because the people living at Botchill House can find visitors, and changes to their routine, unsettling. We wanted to give staff time to prepare people for our visit.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the PIR and other information we held about the service including notifications we had received. A notification is information about important events, which the service is required to send us by law.

Not everyone who lived at Botchill House was able to verbally express their views about living at the service due to their health needs. We observed staff interactions with people throughout the day. We spoke with two people, the registered manager and five members of staff. Following the inspection we contacted another member of staff and three relatives to hear their views of the service.

We looked at three records which related to people's individual care needs, records which related to the administration of medicines, three staff recruitment files and records associated with the management of the service including, quality audits.

Good

Is the service safe?

Our findings

Due to their health needs, people who lived at Botchill House were not able to tell us about their experiences of living at the service. Instead we observed interactions between staff and people and spoke with relatives. Relatives told us they believed their family members were safe. People approached staff throughout the day and were relaxed and at ease with them. Relatives commented; "Oh yes, he is safe" and "He most certainly is [safe]!"

There were sufficient numbers of staff available to keep people safe. We looked at rotas for the previous two weeks and saw the minimum staffing levels had been adhered to at all times. Daily records showed people were supported to go out regularly. In addition to support workers, the service employed a cook and cleaner. A self-employed maintenance worker was available to carry out any repairs and attend to the large gardens.

Recruitment processes were robust; all appropriate pre-employment checks were completed before new employees began work. For example Disclosure and Barring checks were completed and references were followed up. This meant people were protected from the risk of being supported by staff who did not have the appropriate skills or knowledge. Prospective employees met with people who lived at Botchill House as part of the recruitment process. This gave the registered manager the opportunity to observe how they engaged with people and assess if they were likely to get on together.

People were protected from the risk of abuse because staff had received training to help them identify possible signs of abuse and knew what action they should take. Some staff had attended a recent reflective safeguarding training event where they thought through 'real life' scenarios. Staff told us this had been very useful. Posters in the office displayed details of the local authority safeguarding teams and the action to take when abuse was suspected.

There were robust systems in place to make sure people's personal monies were safe. Any receipts were kept and transactions recorded on the computer. We checked the recordings against randomly selected receipts and saw these had been documented correctly.

Risk assessments were generally incorporated into the providers new care planning and record keeping system (iplanit) which had been recently introduced. The system enabled any identified risk to be clearly associated with the related need, as opposed to being stored separately. There was evidence of this in one person's records in relation to their behaviour support plan. The description of the range of behavioural risks was very clear and the early warning signs and potential triggers comprehensively and clearly explained. There was also reference to the persons needs in relation to their recovery time from incidents. Evidence in the incident reports, showed this need was better understood following learning from previous events. Any learning had been incorporated into the support plans and associated risk assessments. The provider, Havencare, had a clinical lead who supported this work. During our discussions with staff it was apparent their understanding of this person's needs corresponded with the support plan.

One person had experienced two episodes of choking in the last two months. A risk assessment was already in place to cover the risk of choking. Following the recent incidents a note had been entered into the communication book which stated; "Continue to observe [person's name] during meal times" and "cut up her bread into bite size pieces and remove crusts." Only 13 of the 21 staff members had signed to say they had read the information. However, when we discussed the risk and what action staff should take to minimise it, it was clear more action was being done, and detail known about the circumstances which could lead to the person choking, than was recorded. For example, the registered manager and a member of staff told us the person had a tendency to eat very quickly. They told us they checked the person had finished what they were eating before leaving the table. This would protect them from choking when unsupervised. This information had not been recorded in the assessment. Although the last incident had occurred over a week before the inspection the risk assessment had not been updated. We could not be sure all staff had read the new information in the communication book and were aware of the incidents and heightened risk. We discussed this with the registered manager who told us they would update the assessment and ensure all staff were aware. They had made a referral to the local Speech and Language Team (SALT) for them to complete a swallowing assessment. Following the inspection the registered manager contacted us to tell us a member of SALT had visited the service. Staff were able to describe how they could support the person to minimise the identified risk.

People's needs were considered in the event of an emergency, such as a fire. People had personal evacuation plans in place. These plans helped to ensure people's individual needs were known to staff and emergency services, so they could be supported and evacuated from the building in a safe way. Regular fire tests were carried out and people were aware of what to do if the fire alarm went off. There were posters in corridors which told people what to do in the event of a fire. These used pictures and simple text and could be used by staff as a communication tool when discussing fire safety with people.

Systems for the management, storage and administration of medicines were robust. A separate room was available where medicines could be stored and prepared safely. There was a dedicated medicines fridge in place and the temperature of the fridge and medicine room was monitored to help ensure it was suitable for storing medicines. The service was not holding any medicines which require stricter controls by law but there were suitable storage arrangements in place if required. Medicines administration records (MARS) were completed appropriately. We checked one person's MAR and the amount of stock tallied with the amount recorded. Staff were appropriately trained and underwent competency assessments before being able to lead on medicine rounds. No-one was required to lead on medicine rounds until both they and the registered manager were assured of their confidence to do so. A second member of staff checked the MAR following administration of medicines. Following a pharmacy audit the service medicines policy had been updated to reflect national guidance when people need to go into hospital.

Good

Is the service effective?

Our findings

People were supported by skilled staff with a good understanding of their needs. The registered manager and staff talked about people knowledgeably and demonstrated a depth of understanding about people's specific support needs and backgrounds. A member of staff commented: "I know all the guys well. You get to recognise when people are getting distressed." People had allocated key workers who worked closely with them to help ensure they received consistent care and support.

New staff were required to complete an induction process consisting of a mix of training and shadowing and observing more experienced staff. The induction process included the new Care Certificate, a national qualification designed to give those working in the care sector a broad knowledge of good working practices.

Training identified as necessary for the service was updated regularly. The registered manager completed a training plan every January to help ensure any gaps in training were identified. Staff were trained in understanding and managing behavioural risks using a widely recognised and accredited approach. They also received training specific to people's needs such as epilepsy and dysphagia, (swallowing difficulties) with a few members of staff having more comprehensive dysphagia training. Staff told us they had enough training and felt equipped to carry out their roles effectively. Relatives told us they had confidence in staff skills.

Staff received regular supervision and yearly appraisals with the service manager. In addition they attended at least four group supervisions per year. These were themed discussions and learning opportunities such as the safeguarding session referred to in the safe section of this report. Staff confirmed they had opportunities to discuss any issues during their one to one supervision, appraisals and at staff meetings. Comments included; "You sit down with [service manager] and go through any concerns" and "It seems like you're always getting supervision!"

Staff sought people's consent before providing care. Staff said they gave people time and encouraged them to make simple day to day decisions. For example, what activities they wished to take part in. People spent time with staff in shared areas such as the lounge and were encouraged to make choices. We saw one person decided they did not want to go out on a planned trip and this was respected.

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 to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application 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.

Applications for DoLS authorisations had been made appropriately. The registered manager had contacted local authorities to check the application had been received and was being dealt with. We did not see any records of capacity assessments to establish whether or not people were able to consent to their plan of care. We discussed this with the registered manager who was able to talk knowledgeably about people's capacity to consent or not to specific decisions. However there was no formal recording of the process. They assured us they would address this.

People ate varied and healthy diets and care plans recorded people's likes and dislikes. The kitchen was well stocked and there was plenty of fresh produce available. Meals were organised to accommodate people's individual preferences. For example, one person particularly enjoyed baked potatoes and they had a separate stock of potatoes available to allow them to choose this option whenever they wanted. Another person had been diagnosed as having a high metabolism. Following advice from a nutritionist they were encouraged to eat high protein foods. The cook organised monthly themed nights when they prepared food from a particular culture or to celebrate a seasonal occasion. For example, they had recently had a Mexican night. This gave people an opportunity to try foods they had not previously had.

People had access to healthcare services when required. For example, everyone had six month dental checks, annual health checks and had received previous reviews by psychiatry specialists as well as others in the local specialist learning disability team. People had health action plans and hospital passports detailing their past and current health needs, as well as details of health services currently being provided. Health action plans helped to ensure people did not miss appointments and recorded outcomes of regular health check-ups. Hospital passports are used to provide healthcare professionals with useful information about people's needs and communication styles when they are admitted into hospital. The registered manager had attended a health promotion event and this had inspired her to develop health promotion material and practices at Botchill House.

Botchill House was a large old style property in a rural setting although close to local amenities. A lift had been installed to help accommodate people's needs as they became less mobile. There was also a stair lift in place. There were plans to turn a bathroom into a wet room which would be easier for people to use. Everyone had their own room and some were en-suite, including those occupied by the two females. Rooms were decorated to reflect people's personal tastes and suit their needs. Some rooms were full of memorabilia and posters reflecting their interests. Another room was very sparsely furnished as the person had indicated this is what they preferred. The room was tiled rather than carpeted. The flooring had a sparkly textured finish and the registered manager told us this met the person's sensory needs. In one area there was an evolving wall of photographs from activities and events that people had been involved in during the year. This helped to facilitate some discussion between staff and people and it was very apparent that they liked having this. There was a large activity room where people could do craft activities or prepare food. There were two shared lounges and a separate dining room. Most people ate in the dining room but two chose to eat together in the activity room. This demonstrated people were able to choose where they spent their time and who with.

Good

Is the service caring?

Our findings

People were supported by staff who were kind and caring and we observed staff treated people with patience and compassion. The interactions we observed between people and staff were very positive. A member of staff told us; "The most important thing is the hands on support." Relatives told us they believed staff were kind and their family members were well cared for. Comments included; "I am very happy that [person's name] is so well looked after in a loving environment and feel blessed he is there" and "I'm very happy and [person's name] is happy. She never complains when she goes back."

People's needs in relation to their behaviour were clearly understood by the staff team and met in a positive way. The door to the office was open for most of the day and people came in and out frequently. At times the door was closed to allow us to have confidential conversations with the registered manager. This was clearly unsettling for people who were used to being able to access the office. For example, there was one incident when someone became upset and wanted to get into the office, which she ordinarily could do. Staff quickly responded and due to her complex communication needs, they competently worked through a process of elimination to identify what might be triggering her distress. This enabled them to quickly and effectively meet her need. When asked about it later, we were told that it was through knowing her for so long and understanding her needs and triggers that enabled them to identify what she wanted so quickly. We asked how new staff got to know the nuances of people's communication needs and styles and were told that, alongside reading care plans and records, new staff had an extensive shadowing process so that they can gently get to know people and people get to know them.

People's communication styles were recognised and respected. Some people conversed verbally, others used basic signing, one person could use Makaton (a simple signing system), and one had a communication book but did not wish to share it with people they did not know. Adapted and respectful communication was evident throughout the visit and included simplified language, person centred communication boards, social stories, use of gestures/signs and some intensive interaction. For example, a social story had been created to let people know we would be visiting and why. Social stories are short descriptions of particular events. They are used to support people with a learning disability or autism to understand what to expect in a specific situation. When we arrived at the service people came out to greet us and said they had been expecting us. The introductions were actively supported by staff. A relative told us staff used a photograph of their home with the person standing outside it to let them know when they were going to visit. They said this was important as the person visited them fortnightly and could become confused about whether it was their week to visit or not.

The registered manager tried to match staff with people who had shared interests. For example, one person was very interested in art and was themselves an artist. They were supported by a member of staff who was also an artist. The staff member told us they supported the person to go on holiday to an area well known for its galleries. This showed people were supported to develop positive relationships with staff.

People were involved in many aspects of the day to day running of the service and allocated roles which were in line with their skills and interests. For example, one person was particular about their laundry and

this was accommodated by them being given space and support to get their laundry done in the way they liked. Other people liked to be involved with clearing up the kitchen or vacuuming.

Staff recognised the importance of family relationships and supported people to maintain them. Staff spoke with families regularly to help ensure they were kept up to date with any developments or changes in people's health needs. There was an active 'Friends and Families' group who helped fundraise to support the service.
People's dignity and privacy was respected. Staff knocked on people's doors before entering and asked people if they would mind showing us their rooms. People had locks on their doors and various types of locks had been tried to help people have more autonomy. For example some people had thumb print locks. Not everyone was able to operate these and the registered manager was researching a new method of locking doors. They told us; "They can't all use them, but if some of them can that's great." This showed people's individual needs were taken into account.

Care plans included limited information about people's backgrounds. This kind of information is important as it can help staff to gain an understanding of past events which may have contributed to who people are today. Most of the staff team had worked at the service for a long time and had an in-depth knowledge of people's preferences and how they liked to be supported.

The people living at Botchill House had lived together for many years. The service manager told us; "They look out for each other." One member of the group had passed away earlier in the year. The person had been supported to stay at the service for as long as possible until they needed specialist nursing care. The registered manager and staff spoke of the person fondly and were clearly moved when remembering them. In the period leading up to the person's death the service had been supported by an end of life expert from the local learning disability team. They had helped develop social stories to support people to understand the various stages of the person's illness. Staff had also received end of life training from a local hospice and dementia training to help them understand and meet the person's needs. Everyone from Botchill House had attended the funeral and they had held a wake afterwards. People were encouraged to remember the person and there was a photograph of them on the wall of the small lounge area. A relative told us; "They were really good at supporting [person's name] when their needs changed. I admired them for that."

Good

Is the service responsive?

Our findings

A new care planning and record keeping system (iplanit) had been recently introduced. This was an online record which was easy for staff to update. People were not able to be fully involved with planning and reviewing their own care or making decisions about how they liked their needs met. Support plans that were accessible for people were under development. This was planned to help facilitate greater involvement in the care planning process and help make care documentation meaningful for people.

There was evidence in the iplanit records and through discussion that people's rights were being actively considered. There were descriptions in the care plans about how to safely maintain the quality of life of one person by actively supporting them to develop their community interests. The support plans included sections on behavioural support and communication needs as well as information about people's health needs and routines. Information was detailed and personalised including guidance for staff on how to support people in order to avoid them becoming distressed or anxious. For example, in one person's plan it was recorded; "I do not like plasters. I will scream if presented with a plaster." Regular reviews were carried out on care plans to help ensure staff had the most recent updated information to support people.

Staff told us the systems in place to help ensure they were up to date with any changes in people's needs were effective. Daily logs were completed throughout the day for each individual. These recorded any changes in people's needs as well as information regarding appointments, activities and people's emotional well-being. The logs had been completed appropriately.

People were supported to develop and maintain relationships with people that mattered to them. For example, people went out with family members regularly. Relatives confirmed they visited regularly and when they wanted to.

The registered manager and staff explored ways of supporting people to express their views. In the past house meetings had been arranged to try and gather people's views but staff had found it difficult to engage people in the process. A new photo based survey system was being developed to help staff explore with people how they felt about their care and lives at Botchill House. This would also be used to record activities people had taken part in.

People were supported to take part in activities outside of the premises on a regular basis. The service had access to a mini bus to enable people to go out in groups. Staff told us another vehicle would allow more people to go out at the same time although they were able to use staff cars if need be. Staff had the appropriate insurance in place to allow them to do this. Two people regularly attended church and staff told us they chose whether or not to do this independently and on a week by week basis. Others attended art and photography groups during the week. One person was being supported to go shopping on the day of the inspection. The registered manager told us staff had worked with the person over a period of time to support them to be more independent when going shopping. They told us the person had now got to a stage where they were able to make choices about what to buy and pay for the transaction with minimal support. This demonstrated staff were responsive to people's needs and identified ways to enable them to

have meaningful involvement in activities.

People's interests and hobbies were recognised and efforts made to allow them to pursue these. For example, one person was particularly interested in tractors. They had access to a number of model and toy tractors. They also had a real tractor parked in the field outside the property where they often spent time.

There was a satisfactory complaints procedure in place. Relatives told us they had no concerns but were confident any issues would be dealt with appropriately.

Good

Is the service well-led?

Our findings

Botchill House was owned and ran by the provider, Havencare. The company had a clear set of values in place and these were communicated through the organisation. A poster in the office outlined the principles of the care provided by Havencare and this formed the framework for care planning and record keeping. It stated that the principles of care were 'Establishing, Engaging, Exploring, Evolving and Empowerment' and then various aspects of care were considered within this, including Independence, Relationships, Community, Money, Meaningful Occupation, Direction and Fulfilment. The registered manager told us they were well supported by the organisation.

There were clear lines of accountability and responsibility in place. Botchill House was overseen on a day to day basis by the service manager. They were supported by the registered manager who was based at the service approximately three times a week. Both had active roles within the running of the service and good knowledge of the people and the staff. Each shift was overseen by a named shift leader who took responsibility for medicines. People had assigned key workers who oversaw their care planning and organised any health appointments.

Staff and relatives were positive about the management of the service and described both the registered and service managers as approachable and available if needed. The service manager told us they regularly worked weekends and evenings so they were aware of any issues which might be specific to these times. A relative commented; "I can't find any fault." Another who lived some distance away told us; "They keep me well informed when there have been any concerns and email me."

Staff were motivated and positive in their approach to people and support. Staff told us they enjoyed their work and one commented; "It feels very unique here." Some members of staff had worked at the service for many years and this meant people received consistent care and support from staff who knew them well and understood their needs.

There was a quality assurance system in place to drive continuous improvement within the service. Audits were carried out in line with policies and procedures, for example audits on care plans. Havencare's clinical lead visited regularly to help develop support plans when people's needs changed. They also acted as the CQC lead working with the service to help ensure they were meeting the regulations. To help achieve this they carried out unannounced site visits on behalf of the provider to audit various aspects of the service including infection control, any physical intervention logs and medicines. These occurred two or three times a year. Regular audits and maintenance checks were completed which related to health and safety, the equipment and the home's maintenance such as the fire alarms and electrical tests.

Systems were in place to help ensure reports of incidents, safeguarding concerns and complaints were overseen by the area manager or the company's senior management. This helped to ensure appropriate action had been taken and learning considered for future practice. We saw incident forms were detailed and encouraged staff to reflect on their practice.