Care Quality Commission

Care UK Community Partnerships Limited

Heavers Court

Inspection report

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Ratings

Overall rating for this service	**Good**
Is the service safe?	**Good**
Is the service effective?	**Good**
Is the service caring?	**Good**
Is the service responsive?	**Good**
Is the service well-led?	**Requires Improvement**

Overall summary

We visited Heavers Court on 11 and 12 December 2014. The inspection was unannounced.

The service provides residential and nursing care for up to 60 people with dementia.

The service had a registered manager until 1 December 2014. '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.' The service was in the process of recruiting a new manager.

People at the service felt safe and secure. Staff knew how to recognise and respond to abuse and had completed safeguarding of vulnerable adults training. They knew how to report safeguarding incidents and escalate concerns if necessary. The service provided a safe environment for people, visitors and staff. People's needs were assessed and corresponding risk assessments were developed. There were sufficient numbers of staff to meet

Summary of findings

people's needs. Medicines management was safe. We saw that people were receiving their medicines safely and as prescribed. Improvements were needed to the records of application for topical medicines, such as creams.

Staff had the skills, knowledge and experience to deliver effective care and treatment. Mental capacity assessments had been completed to establish each person's capacity to make decisions and consent to care and treatment. Where it was necessary to deprive people of their liberty the service had obtained appropriate authorisations under the Deprivation of Liberty Safeguards. People were supported to have a healthy diet and to maintain good health. There were some concerns about choices of meals for people.

People commented positively about their relationships with staff and we observed numerous examples of positive interactions. People and their representatives were supported to express their views and were involved in making decisions about their care and treatment. Keyworkers provided additional support for people.

There were meetings for people and relatives where they could express their views and opinions about the day to day running of the home. Staff respected people's privacy and dignity.

People received personalised care. Care plans were person centred and addressed a wide range of social and healthcare needs. People were involved in the development of their care and treatment. Care plans and associated risk assessments reflected their needs and preferences. People were encouraged to take part in activities which reduced the risks of them becoming isolated, frustrated, bored and unhappy. People were confident that they could raise concerns with staff and those concerns would be addressed.

There were concerns about the number of changes in the management team and the lack of consistency and communication. We were informed that the service was in the process of recruiting a permanent manager. (Since the inspection a manager has been appointed and was in the process of registering with the Care Quality Commission). There was a system of internal and external audits to monitor and assess service provision.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was safe. People felt safe. Staff understood their responsibilities to protect people from the risk of abuse or harm. There were enough staff to support people's needs. The service provided a safe and comfortable environment. Medicines were administered appropriately.

Good

Is the service effective?
The service was effective. Staff received regular training and management support. Mental capacity assessments had been completed to establish each person's capacity to make decisions and consent to care and treatment. Authorities under the Deprivation of Liberty Safeguards had been obtained when required. People were supported with their health and well-being.

Good

Is the service caring?
The service was caring. People spoke positively about staff who were aware of people's needs, preferences and planned care and support. People were supported by a keyworker and involved in their care and support. Staff respected people's privacy and dignity.

Good

Is the service responsive?
People received personalised care. Care plans were person centred and addressed a wide range of social and healthcare needs. People were involved in the development of their care and treatment. People were confident that they could raise concerns with staff and those concerns would be addressed.

Good

Is the service well-led?
The service was not well-led. There were concerns about the number of changes in management and the lack of consistency and communication. The service did not have a registered manager. We were informed that the service was in the process of recruiting a permanent manager. (Since the inspection a manager has been appointed and was in the process of registering with the Care Quality Commission). There was a system of internal and external audits to monitor and assess service provision.

Requires Improvement

Heavers Court

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 11 and 12 December 2014 and was unannounced. The inspection team comprised three inspectors and a pharmacy inspector. 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 also reviewed information we held about the service which included statutory notifications and safeguarding alerts sent to us by the provider. We spoke with seven people using the service, six visitors and eighteen members of staff including the manager. We carried out general observations throughout the inspection. We looked at records about people's care and support which included 14 care files. We reviewed records about staff, policies and procedures, general risk assessments, accidents and incidents, minutes of meetings, complaints and service audits. We inspected the interior and exterior of the building and equipment used by the service.

Good

Is the service safe?

Our findings

People felt safe. One person told us, “Staff do look after us and keep us safe. We keep each other safe.” Another said, “It’s okay, there are no problems here.” One person commented, “I feel safe here.” Another said, “I feel safe and secure.” A visitor told us, “There always seem to be enough staff around. Another visitor said, “Staff are always kind and take time to explain things to us.” One visitor told us that there were times when there did not appear to be sufficient staff which was particularly noticeable when they were dealing with challenging behaviour.

We spoke with staff about safeguarding vulnerable adults from abuse. In our conversations it was apparent they knew how to recognise the various types of abuse and the procedures for reporting abuse. They were aware of how to escalate concerns and whistle blowing procedures. Staff told us they were confident that they could report any concerns and they had received safeguarding training. This was confirmed when we looked at training records. In addition to the training provided the service had safeguarding policies and procedures to support staff. We checked our records and saw that the service had complied with legislative requirements by notifying us of safeguarding concerns when they arose. We also saw there was a policy for people’s finances and regular checks to minimise the risks of financial abuse.

We found that the service was a safe place for people, staff and visitors. The building was purpose built to provide residential care and nursing for people with dementia. The building was well maintained as were the surrounding gardens and car park and the inner courtyard. The building was owned by the London Borough of Croydon, Eldon Housing Association provided maintenance and catering services, and Care UK provided the residential and nursing care. We noted that regular fire drills were carried out and selected staff had been appointed as fire safety coordinators. In addition to nursing staff there were appointed first aiders on each shift. We also saw there were personal call systems in each room enabling people to call staff from their rooms if necessary.

Formal handovers took place between shifts so that staff were aware of incidents that had happened on the previous shift and how individuals were feeling and behaving. We observed two handovers in different parts of the service. We found that staff demonstrated a good knowledge of the people they cared for. Information at handovers about people’s needs was given in a clear and concise way and included topics such as how people had slept, personal care administered, food and drink and medicines. Other information referred to specific incidents that cannot be included in this report.

We found that people were assessed before they moved into the service. This pre-admission assessment involved input from people and relatives and where appropriate professionals. The assessments included an assessment of risks to people and formed the basis for more detailed care planning including associated risks. The service had a clearly defined admission programme whereby care plans and risk assessments were completed within 48 hours of admission. These were reviewed monthly or in response to changes in people’s needs. We looked at risk assessments in care plans and found they addressed a wide range of risks and supported staff to meet people’s needs. Risk assessments provided staff with clear information about the nature of each identified risk and how to manage it. For example, one a risk assessment related to one person’s use of a wheelchair. This risk assessment covered checking the condition of the wheelchair, transfer to and from the wheelchair, sitting position and use of a lap belt. It also referred to related risks such as the FRASE assessment about the risk of falls.

We spoke with staff and they felt there were enough staff to meet people’s needs. Occasionally, when individuals were challenging or when staff were taking breaks it could get very busy, but that was only for short periods of time. One visitor told us they had witnessed a dispute between two people in one of the lounges. One member of staff was making a cup of tea for another person and had to stop to intervene in the dispute. There were occasions when we saw individual members of staff but that coincided with staff breaks or staff were assisting somebody in their room. We looked at staff scheduling and spoke to senior staff. We were satisfied that there were sufficient numbers of staff on duty. Staff were supported by administration, catering and domestic staff that enabled them to concentrate on meeting people’s care and nursing needs. Planned absences of staff for commitments such as training and leave were accommodated within staff scheduling. Short term absences were covered by staff working overtime or from bank staff. The service only used agency staff for nurse absences. However, we were told that there was quite a high turnover of care workers joining and leaving mainly as

Good

Is the service safe?

the result of a recruitment drive at the local hospital offering a better financial package. The manager told us they had lost some staff but had managed to replace them. There was 24 hour on call arrangements so that senior staff could be contacted for advice and support if they were not on duty. We found that care staff were experienced and appropriately trained and qualified. Approximately a third of care workers possessed a qualification equivalent to National Vocational Qualification Level 2 or above in Health and Social Care. We found that staff were encouraged and supported to complete such qualifications.

Medicines were managed safely. All medicines, including controlled drugs, were stored securely. and administered by appropriately trained staff. Staff were assessed as competent before they were allowed to administer medicines to people. Their competence was reassessed once a year. Staff were aware of recent changes to controlled drugs regulations and we saw medicines were managed in line with current medicines good practice.

We saw that there was an "Administration of medicines" care plan for people with their medicines administration record which gave staff sufficient instructions to administer medicines correctly. For example, someone was prescribed a medicine which increased the risk of bruising and this was recorded on their care plan. This meant staff were aware of the risk when they were providing personal care or moving this person. Another person was prescribed an inhaler for asthma. Their care plan provided instructions to staff on how to administer the asthma inhaler correctly, and how to monitor their asthma symptoms. Some people were prescribed sedating medicines for agitation or challenging behaviour. Care plans were in place to explain when these should be used. We saw that staff always recorded the reasons when they administered these medicines. We saw that these medicines were not being used inappropriately or excessively to control people's behaviour. We found some people with dementia were prescribed anti-psychotic medicines. Because of the risk of prescribing these medicines we discussed this with the prescriber who told us these medicines were only prescribed for short periods in line with current guidance for the use of anti-psychotic medicines in older people with dementia.

Some people were unable to communicate to staff when they were in pain. We saw they were receiving pain relief because care plans helped staff to identify when these people were in pain. Some people who did not have capacity make decisions about medicines had been regularly refusing essential medicines. We saw procedures were recorded to give these medicines covertly, in food or drink, in line with the requirements of the Mental Capacity Act 2005. Care plans gave staff guidance on how to administer these medicines. This meant that people without capacity continued to receive essential treatment.

There was an effective system for ordering medicines, to ensure they were available for people at all times. Up-to-date and fully completed records were kept of oral medicines received, administered and disposed of, including a clear record when people had allergies to medicines. These records provided evidence that people were consistently receiving their oral medicines safely and as prescribed. Improvements were needed in records for the application of topical medicines such as creams. We saw that there were gaps on some of these records. Staff told us that creams had been applied but that they did not always sign the topical medicines application record when they did this. Therefore we could not tell whether these creams were always used as prescribed. The manager had already identified this issue prior to our inspection, and there was a plan in place to make improvements to these records.

Good

Is the service effective?

Our findings

People were cared for by staff who had the knowledge and skills they needed to carry out the role. One member of staff told us, "The training here is good so is the support we receive from team managers." Another member of staff said, "It's really great here, I love my job. I had an induction, then I shadowed other [staff] for two weeks and then I was observed [by experienced staff] for a week. Another told us, "It's a nice home. I'm all up to date, the training is fine." A team leader told us that the induction process was created by Care UK and had been personalised to meet the needs of this service. New recruits had to complete a competency folder that was witnessed by other members of staff they worked with. We examined the training matrix and saw that there was regular training for staff deemed 'mandatory' by the service. Mandatory training was provided in house by a trainer employed by Care UK.

Some members of staff were champions for specific areas of care and provided training in those areas. For example, one team leader was the lead for manual handling and took the responsibility very seriously. They showed us detailed records of what training was provided and who had completed it. If training was required that was not available from staff or the trainer Care UK provided a list of external companies to provide it. Two members of staff told us the service supported people to obtain qualifications relevant to health and social care. We looked at a selection of staff files and saw that staff were supported with supervision sessions from line management. We found that supervisions included specific issues that were relevant to the service as well as the performance of individual members of staff. For example, the supervision records we looked at included the importance of completing the medicines' administration record for topical medicines.

The service had policies and procedures for the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). People had mental capacity assessments and if they lacked capacity they were supported by relatives or other bodies legally appointed. We saw evidence of consent in care records. Where required, the service had applied to the relevant local authority for DoLS authorisations. One example was in relation to people having bed rails raised when they were in bed. Where people lacked capacity to make that decision they had applied for a DoLS authority to do so. We spoke with three members of staff about mental capacity and DoLS. They showed that they had an understanding of these areas and told us they had received training.

People had sufficient food to eat and liquids to drink. People were provided with a balanced diet and if necessary specific dietary needs were accommodated. Throughout the inspection and whilst observing mealtimes we saw people had cold drinks next to them or were being offered drinks. People were encouraged to drink by staff. On person told us, "The food is good, can't complain." Another person said, "Food's alright, plenty of tea. They are looking after me alright." We observed one member of staff assisting a person who was unable to feed themselves. They were caring and considerate. They gave the person time to finish each mouthful before asking if they were ready for the next. They encouraged the person making comments such as, "You are doing well" and "Take your time." The food provided was hot and there were choices. However, both visitors and staff complained that people had to choose their meal option three days in advance. People often forgot what they had chosen or changed their minds. Sometimes a person missed out on their choice because it had run out. Another member of staff told us that if for some reason the menu choice was not completed people did not receive a cooked breakfast even if they wanted one. We could see no reason why people had to choose what they wanted to eat in three days' time or having made a choice missed out. Effectively, there was a restriction of choice. We spoke to the manager and senior staff about this unsatisfactory arrangement. We were told that there been communication issues between Care UK and Eldon Housing Association but there had been improvements. As a result of our inspection the service reviewed this practice and made improvements.

People were supported with their healthcare needs. The GP visited the service twice a week and at other times if required. Other multi-disciplinary services attended when required including mental health services and occupational therapists. People were supported to attend dental, chiropody, optical and other medical appointments within the service or externally. We saw evidence of healthcare needs being met in care records. People were weighed at least once a month or more often if required.

Good

Is the service effective?

We saw more detailed clinical observations for those people requiring nursing care. We spoke briefly with two visiting doctors who provided positive comments about the service.

The service was piloting a telehealth system called Myclinic. The driver behind the system was a need to decrease the number of people with dementia being admitted to hospital within the London Borough of Croydon (which has more people with dementia and more dementia care homes compared with other London boroughs). People with dementia were often unable to communicate their healthcare needs to staff. Consequently, people with dementia were more likely to be admitted to hospital with avoidable conditions such as dehydration or urinary tract infections. People with dementia admitted to hospital tended to stay longer and had poorer outcomes. The service initially selected 12 people with late stage dementia after consulting their families. Each morning a member of staff recorded people's vital signs on an electronic tablet which were securely communicated to a clinical triage team. Any readings falling outside parameters set for each person were flagged to the manager to take appropriate action. The service's dedicated GP also had access to the system. The system enabled early intervention and prevention and hopefully would reduce hospital admissions. Myclinic was proving to be an effective support system but it had not been fully evaluated at the time of the inspection.

Good

Is the service caring?

Our findings

We spoke with people about their relationships with staff. One person told us, “They are lovely people, they really are. They take good care of me here.” One person said, “Staff always go that extra mile to meet our needs.” Another person said, “They’re a great crowd here, I’m quite happy. The nurses really look after me.” One person told us, “Staff are very polite, we have a lot of fun, I have never laughed so much in my life.” Another said, “They are lovely people they really are.” A member of staff said, “I always treat people the way I would want to be treated.”

We observed and listened to interactions between people and staff throughout the inspection. The following are just some of the positive examples we observed. A member of staff spoke to a person coming out of their room and suggested in a friendly manner that they might want to put a cardigan on because it was cold. The person chose to do so. We saw a nurse laughing and joking with two people. During a medicines round a nurse woke somebody slowly telling them it was time to take their medicine. As the person awoke the nurse said, “It’s lovely to see you smile first thing in the morning.” The nurse patiently administered the medicines and did not rush the person. We saw one member of staff bringing a person from their room holding their hand. The person was not rushed and was smiling whilst talking. In one lounge we saw two care workers dancing and singing with people. It was evident from people’s reactions and facial expressions that they were enjoying themselves. At other times we saw members of staff sitting and chatting with people. We did not see any members of staff standing around doing nothing. They were either engaged in tasks or they were interacting with people.

When people were admitted to the service they were assigned a member of staff as a key worker. This provided people and relatives with a recognised member of staff they could approach with concerns or problems. People had a keyworker throughout their time at the service. The keyworker got to know them more closely and provided an additional layer of support. They also contributed to people’s care plans and risk assessments. One keyworker told us that they got to know one person very well and had raised concerns with the local authority about their financial support. Other members of staff said they provided additional support as a keyworker around day to day living. When we spoke with people they were able to tell us who their keyworker was and staff told us who they were assigned to as a keyworker. We also found that staff had a good knowledge about people’s needs particularly in the area of the building they normally worked.

We found people, their relatives or representatives, were supported to express their views and were actively involved in their care and treatment. When we looked at care plans we found evidence of people and their representatives being involved. People’s choices and preferences were recorded. For example, one plan stated the person liked their door to be left open and the bathroom light left on. One person liked a hot drink before going to bed. Medicines records described how people liked to receive their medicines.

Staff respected people’s privacy and dignity. One member of staff told us, “I always make sure I protect people’s dignity when responding to their needs.” Another told us, “I always treat people the way I would want to be treated. I speak to each person and explain what I am doing. You can tell by their eyes or facial expression if they are happy.” We observed staff knocked at people’s doors and spoke before entering rooms. Staff explained to people what they were about to do when carrying out care and treatment. We saw people were appropriately dressed and appeared to be wearing their own clothing. People were well presented with clean nails and hair. Gentlemen were clean shaven where appropriate. The service tried to meet people’s spiritual needs. There were monthly Church of England and Roman Catholic services. Other spiritual needs were addressed on an individual basis.

Is the service responsive?

Our findings

People received care that was responsive to their needs. A relative told us, "The carers are really good. They are always encouraging people to join in with different activities." We looked at a selection of care plans. These records were on a computerised system called Caresys. The system was relatively new but staff were positive about its benefits. We did find there were hard copies of care plans. The care plans were person centred and identified people's care and treatment needs. Near the front of the record was a 'Care Needs Summary' for easy reference which led onto more detailed care and treatment plans and risk assessments.

The care plans referred to the people by their preferred name. They reflected people's choices and preferences. For example, we saw that one person did not like her glass to be filled and preferred small portions of food. There was a section for 'Lifestyle and Interests' which provided information such as: I like to be called…; My family life; My working life; Important people; Important dates; and, Special thoughts. This section provided staff with information about people's background and history and their interests to help them provide personalised care. The care records also identified people's key worker and their GP. We spoke with one member of staff who told us about the background of one person. They liked to know about people's history because it gave them ideas for things to talk about that might trigger memories for a person with dementia and provide comfort when they were confused.

We found that people benefited from various activities which reduced the risk of people becoming isolated, frustrated, bored and unhappy. These activities ranged from people carrying out day-to-day tasks to daytrips out. If able, people were encouraged to main as much independence as possible by carrying out daily living tasks such as personal care, making drinks for themselves and reading. We saw ad hoc activities instigated by individual members of staff including sitting and talking to individuals, dancing with people and singing. One member of staff was painting people's nails and told us they also did some hand massage when there was time. The service arranged activities within the home such as art and crafts, exercise sessions, gardening and visits from entertainers. There were also excursions arranged for small groups such as trips to central London and to the coast. The service had a sensory room where people should have been able to enjoy a variety of sensory experiences. However, the room appeared to be used as a cinema and for training and storage. There was support from the Friends of Heavers with activities. Friends of Heavers are a volunteer group who provide additional support to people living at Heavers Court. They also enhanced people's experiences of living at Heavers Court by providing additional activities and by contributing items. The furniture in the courtyard had been contributed by the Friends. The service collaborated with the Friends of Heavers to produce a newsletter twice a year.

The service had systems to listen and learn from people's experiences, concerns and complaints. The Friends of Heavers organised periodic meetings for people using the service and their relatives. At these meetings people and relatives could raise issues about the day to day running of the home. There was a complaints policy at the system at the service to deal appropriately with any complaints. Most people or relative told us that they would raise issues with a member of staff and in most cases the matter would be addressed. We looked at the record of complaints and saw they were responded to and investigated in a timely manner. An external body carried out an annual survey of the experiences of people and relatives. The responses were collated and fed back to the manager.

Requires Improvement

Is the service well-led?

Our findings

Staff were concerned that the management team kept changing and there was a lack of continuity. One told us, “There’s been lots of ups and downs here recently. It doesn’t feel like there’s clear leadership.” Another said, “The communication is not good.I’ve never been able to go to a staff meeting but nothing is cascaded down. I’ve never seen any minutes.” Another member of staff said, “We have staff meetings regularly. We talk about outcomes and how they relate to residents.” One member of staff told us, “There has been a lot of management change. It impacts on staff, constant transition.”

The registered manager left the service on 1 December 2014. We were told that the manager had been in post for a long time but had to take a lengthy leave of absence. The manager returned for a short period and then left. As a result, the service had used temporary managers over the 12 month period preceding the inspection. In addition, the clinical lead for the service was a temporary posting who informed us during the inspection that they were moving to another home. A new temporary manager was posted to the service during the inspection. The new manager could not say how long they would be in post other than saying they anticipated remaining there until the appointment of a permanent manager. The service and staff confidence would benefit from the consistency provided by a permanent manager and management team.

There were a number of internal and external audits used by the service to assess and monitor the quality of service provision. These included audits covering a range of areas including infection prevention and control, medicines, care and treatment plans and training. There were audits by the regional manager once a month. Audits resulted in reports and actions where failings were identified. There were regular visits from the local authority which commissioned services at Heavers Court.