

Hightown Housing Association Limited

Wendover Road

Inspection report

87 Wendover Road
Stoke Mandeville
Aylesbury
Buckinghamshire
HP22 5TD

Tel: 01296615403
Website: www.hpcha.org.uk






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Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?	Requires Improvement 
Is the service effective?	Requires Improvement 
Is the service caring?	Good 
Is the service responsive?	Good 
Is the service well-led?	Requires Improvement 

Summary of findings

Overall summary

This inspection took place on the 31 March and 1 April 2016 and was unannounced. The home was previously inspected in August 2013 when it was found to meet the requirements of the regulations.

The home is a four bedroomed bungalow. There are shared areas such as a lounge, bathroom, kitchen and dining area. The registered manager was on long term leave at the time of the inspection. The service was being overseen by an interim manager, who planned to be present at the home for two days per week.

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.

Each person had a support plan and risk assessments in place to guide staff on how to provide care and minimise the risk of harm. One person's plan and risk assessment gave insufficient clear guidelines for staff on how to support a person with behaviour that was challenging. We have made a recommendation about supporting staff with writing support plans. Another person had a support plan for exercise, which was written in such a way as to deprive them of choice or control over participating in the exercise. This was removed following the inspection.

Although the provider carried out the necessary checks when recruiting new staff, they failed to check gaps in some candidate's employment histories. We have made a recommendation about the recruitment of staff.

People were appropriately supported with their food and fluid intake. Where specialist advice had been sought to ensure people could eat and drink safely this had been carried out by staff. Medicines were safely stored and administered. Records were up to date and showed people received their medicines at the time they needed them.

Staff had a basic understanding of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). Where restraints had been put in place to keep people safe, authorisation had been applied for from the local authority.

Staff knew how to keep people safe and how to identify and report concerns of abuse. They also understood how to respond to complaints.

Staff received training in areas they needed to know to carry out their role safely. However records of staff training were not up to date or accurate. The interim manager did not have access to all the staff training records at the time of the inspection. This meant they could not assess the safety of the service in relation to the skills and knowledge of staff.

We found some areas of the home were in need of redecoration due to peeling and stained paint work, damaged wood work and structural defects within the parking area. Other parts of the house were well maintained and were well decorated such as people's bedrooms and the lounge area.

People participated in activities both in the home and in the local community. People were assisted to maintain their health through regular contact with the relevant health professionals, for example, GP and dental practices.

Staff worked well as a team. We observed them to be caring and sensitive in their approach to supporting people in the home. They were focussed on supporting the people well and supporting each other. They knew how to preserve people's dignity and privacy and communicated well with people.

Audits and checks were undertaken to ensure the safety of the service and drive forward improvements. We noted that the areas we found in relation to the writing of support plans had not been identified by senior staff during their audit. We have made a recommendation about the providers audit process.

Staff were positive about the skills and knowledge of the interim manager covering the registered manager's position whilst they were on leave. The staff appeared to work well together and there was an honest and transparent approach. Staff felt confident to raise concerns and to seek support when needed.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement ●

Some aspects of the service were not safe.

Some support plans and risk assessments were not all written in sufficient detail to protect people and staff from harm.

Although the provider carried out checks on prospective staff, they did not always check gaps in candidate's employment history. This increased the risk of unsuitable candidates being employed.

Is the service effective?

Requires Improvement ●

Some aspects of the service were not effective.

Training records for staff were not correctly recorded and in some cases inaccurate. They were not accessible to the interim manager.

A person's support plan did not protect them from psychological harm as it placed restrictions on their freedom and choice.

Some areas of the home required internal redecoration and external structural improvements.

Is the service caring?

Good ●

The service was caring.

Staff were kind and considerate to the people who lived in the home.

When people became distressed or anxious, staff responded in a calm but reassuring way.

Is the service responsive?

Good ●

The service was responsive.

People's care was reviewed regularly. Care plans and risk assessments were in place to guide staff on the safest way to

provide care.

People were encouraged to maintain contact with their families.

Is the service well-led?

The service was not well led.

Audits of how the service operated did not identify the concerns we found in relation to how people's care plans had been written. This placed people at risk of receiving poor care.

Staff worked well as a team, they were focused on the people they were caring for, and supported each other. They told us they had confidence in the interim manager.

Requires Improvement 

Wendover Road

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 the 31 March and 1 April 2016 and was unannounced. Prior to and after the inspection, we reviewed previous inspection reports and other information we held about the home including notifications. Notifications are changes or events that occur at the service which the provider has a legal duty to inform us about. The provider completed a Provider Information Return (PIR) prior to the inspection. 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. The inspection was carried out by an inspector.

During the inspection we spoke with four staff including the interim manager. The registered manager was on long term leave and therefore was not present for the inspection. We were not able to speak with the people who lived in the home due to communication difficulties. We spoke with one relative. We carried out observations of care and reviewed documents associated to four people's care and their medicines. We reviewed records related the employment of four staff and audits connected to the running of the home.

Is the service safe?

Our findings

A person's relatives told us they felt the service was safe. Staff knew how to identify indicators of abuse and what action to take and who to notify if they had concerns someone was being abused.

Each person had support plans and risk assessments in place to advise staff how to support people safely and in line with their preferences. We had some concerns about the wording of one of the support plans which had been written to guide staff on what action to take when a person's behaviour was challenging. For example, staff were instructed to "action a negative response" and then "ignore" the person. There were no details about what the negative response should have been or how long the person should be ignored for. This was left open to the interpretation of the staff members. The risk assessment which supported this care plan stated that if the person grabbed a staff member or another person, staff should "carefully remove their grasp." There were no further instructions or guidance on how this should be done. Furthermore the risk assessment stated the person "should be removed from that area and to be allowed back when they had fully calmed down." The guidance did not refer to how the person was "removed" this again was left open to interpretation. Neither the support plan nor the risk assessment clearly stated how staff should support the person with their behaviour. This placed the person at risk of harm. The provider had a restrictive physical intervention policy in place. Other risk assessments clearly advised staff on the safest way of working.

The provider carried out the necessary checks when recruiting staff to make sure they were suitable to work with people. These checks included evidence of disclosure and barring service (DBS) checks. The DBS helps employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups. Although the original documentation was stored in a different location, records demonstrated that applicants had completed application forms and references had been obtained from previous employers. However, we were concerned that gaps in candidate's previous employment histories had not been investigated and recorded. Without these checks being carried out, unsuitable candidates could have been employed to work with people.

We observed there were three staff plus the interim manager on duty on both days of the inspection. The interim manager told us the staffing levels were calculated in relation to the funding provided by the local authority and the specific needs of individuals. This meant the local authority carried out an assessment of each person's needs and allocated funding to pay for staff to enable the person's needs to be met. They told us they were funded for two staff during the day, but they provided three. At night a sleeping night staff member and an awake night staff member were present in the home. However, one staff member and a relative told us that occasionally there were only two staff members on duty during the day. The interim manager told us they had recognised this shortfall happened occasionally when staff were not available to work at short notice. As the interim manager was taking over the management of the staff rota and they would ensure there were safe numbers of staff on duty at all times. Due to the absence of a registered manager and deputy manager, the interim manager planned to spend at least two days per week in the home, whilst managing another service. As the other service they managed was only a short distance from Wendover road they were able to respond quickly if needed.

We reviewed the storage and administration of medicines with the interim manager at the home. People's medicines were stored in a locked cupboard in their bedrooms. Up to date medication administration records, showed staff had signed when medicines had been given to people.

Protocols for the administration of 'as required' medicines were available. These protocols provided guidance as to when it was appropriate to administer an 'as required' medicine and ensure that people received their medicines in a consistent manner. The protocols described how a person may demonstrate their requirement for the medicine, so that staff knew when it was appropriate to administer it. As the medicines were being administered to people who may not be able to verbally request the medicine this was important information.

Care plans described how the person preferred to take their medicines and if the person was able to swallow tablets or required the tablet to be placed on a spoon with yogurt. Checks were completed on the amount of medicines being stored for each person against what was received and administered. Three observations were completed on each staff member when administering medicines to people before they were passed as competent to carry out the task. This was to ensure staff were carrying out this task safely and correctly. Staff received training on how to administer medicines and carry out safe recording practices.

Documents showed risks to people's health and welfare had been assessed and risk assessments had been completed. Care plans informed staff how to reduce the risk of injury to them and to people, for example, how to support people when out in the community. These were reviewed frequently. Staff adhered to speech and language therapy guidance when preparing food and drinks. For one person drinks were thickened and food was pureed to ensure the risk of choking was minimised.

Staff told us they were kept informed of any changes to people's immediate care needs during the shift handover where a verbal handover was received, other information was documented in the communication book, which staff read when they came on shift. This was to ensure care was appropriate and safe.

Safety checks were undertaken to ensure the safety of the building and the equipment, this included maintenance and checks of the water supply to prevent legionella and the fire equipment and alarm systems. Documents demonstrated regular fire drills were carried out at the premises.

We recommend that the service seek advice and guidance from a reputable source, about supporting staff when writing support plans and risk assessments for people who may challenge the service.

We recommend that the service finds out more about recruitment processes, based on current best practice, in relation to safer recruitment.

Is the service effective?

Our findings

A relative told us they believed the staff were well trained to carry out their role. We were told by the interim manager when new staff began work for the service they received induction training in the areas deemed mandatory by the provider. They were also issued with workbooks, which covered areas of work relevant to their role. A series of questions required answers and these were checked by the supervisor to ensure staff understood the requirements and responsibilities of their roles. Staff told us they felt they had received sufficient training to carry out their job. We looked at the staff files to see what training had been completed by each staff member. Information was incomplete. We asked to see the training matrix. The interim manager had not been given access to it. The interim manager requested the training information for the staff at Wendover road to be sent to her. The information that was sent was inaccurate as it showed some staff had not attended training, which they had. It included staff members from other services. We were therefore unable to assess whether staff had the up to date and required training to carry out their role. Without clear and up to date information regarding the skills and training of the staff the interim manager would not be able to assess the safety of the service.

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

Records indicated staff received support from the registered or deputy manager through regular supervision and appraisals. Documents showed this allowed both parties the opportunity to reflect on the performance of the staff member and where appropriate to develop plans for improvement. Staff told us they felt supported and any feedback they received was constructive. It also allowed staff to raise concerns or questions and to suggest improvements in how care could be delivered.

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 are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. Where restrictions were in place to maintain people's safety appropriate DoLS applications had been sent to the local authority for authorisation. DoLS applications had been authorised. Best interest meetings had been held to discuss and agree a best interest decision on behalf of people who did not have the mental capacity to decide for themselves.

We were unable to verify if all staff had been trained in MCA and DoLS but they demonstrated a basic understanding of how MCA applied to their role. We had concerns related to the support offered to a person.

A support plan had been written to assist a person to lose weight and take regular exercise. The support plan stated "X must get some exercise twice a day morning and afternoon." It went on to state ""X may become agitated and hit herself or try to hit staff, but the walk should continue." The support plan does not appear to be giving the person a choice by using the word "must." It acknowledged the person may be unhappy with the activity but that staff should ignore the behaviour and carry on. The support plan stated the person lacked the capacity to comment on the support plan. This placed the person at risk of psychological harm as it placed restrictions on their freedom, choice and control. Following the inspection the interim manager informed us they had removed the support plan and they were going to seek the advice of a dietitian. The person would no longer be made to carry out the daily exercise but would be invited to walks in countryside and parks.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

During our inspection we found there were areas of the home in need of redecoration. The shared bathroom had areas of paint peeling off the walls, the hallway was also in need of repainting and remedial work was required on the skirting boards which were damaged. The dining area required re painting as the walls were marked and stained in places. We saw that the parking area to the front of the premises had sunk in one area; this resulted in flooding when it rained. This meant people's access was restricted. We spoke to the interim manager about all the areas that required improvement and maintenance. We were informed the provider had a five year redecoration programme which meant the home would not be redecorated for the next two to three years. The peeling and stained paint work and damaged woodwork also presented as an infection control concern, as this would make cleaning more difficult and less effective. The flooded parking area presented a risk to people, staff and visitors.

This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

People were supported with their hydration and nutritional needs. Where people required support with eating or drinking this was provided by staff. We observed how people were supported with their lunch. Food was prepared in line with people's care plans. Where people required food and fluid to be thickened or pureed this was done to reduce the risk of choking. We observed one person who was at risk of choking. They coughed and appeared to choke throughout their meal. Staff were kind and supportive and had prepared their food and drinks in accordance with the speech and language therapist (SALT) guidance given in 2013. The advice from the SALT was to re-refer the person if they were choking when eating. This had not been done and it was evident to us this was a problem on the day of the inspection. We spoke to the interim manager who advised us they would make an immediate referral.

Menus were designed with people's likes and dislikes in mind. Regular tasting sessions were carried out to find out what people liked and disliked. The findings were incorporated into the menus. Where people did not like the food provided alternatives were offered.

People were assisted to access the healthcare support they needed when they required it. A range of professionals were involved in assessing, planning, implementing and evaluating people's care and treatment. Documents showed the home liaised with external professionals including the GP, dental practices and speech and language therapists.

Is the service caring?

Our findings

One relative told us they thought the staff were caring. They stated "I think the home is really really good. You can see the love they have for X by what they are doing. If X wasn't happy she would show it." They went to describe the service as "It has a really homely feel about the place, the staff are friendly, it is like going into someone's home."

We understood that the people living in the home had limited ability to communicate with us verbally. Care plans addressed how staff could interpret people's communication through reading their body language and their facial expressions and behaviour. We saw how staff communicated in a way that was meaningful for people, for example, by using minimal language.

From our observations we saw staff interacted with people in a positive and sensitive way. Staff clearly knew about the needs of people and treated people with respect. For example, they used people's names and allowed people space and time if they needed it. A relative told us when they last visited the person they were in their bedroom. To them this indicated the person was able to make choices about how they lived their life and spent their time. There was a good rapport between staff and people, who appeared relaxed in the company of staff. Staff knew the importance of encouraging people to be as independent as possible. A staff member told us how they involved people in the different aspects of their care, for example, encouraging people to make choices about food, and allowing people to do what they can for themselves.

Staff knew how to protect people's dignity and privacy. They told us they knocked on people's doors before entering and closed curtains and doors when supporting people with their personal care. One staff member told us they showed respect to people by amongst other things respecting the person's personal belongings, by talking to them as adults. Staff were able to demonstrate how they supported people's cultural needs and human rights. Where people were from different cultures their cultural needs were acknowledged and respected. People were given the right support to maintain relationships with family members and friends.

Through observations we could see how staff's communication and planning was effective to meet the needs of the people living in the service. Staff worked together as a team to ensure people's needs were met. Although people's expressive verbal skills were limited, it was clear they picked up on the atmosphere in the home. Staff were friendly and included people in jokes and laughter. When people became distressed or anxious, staff responded in a calm but reassuring way.

Is the service responsive?

Our findings

People's care was reviewed regularly. A relative told us they were involved in discussions about the person's care and were consulted with when changes were required. Care plans included people's needs and how they should be met by staff, for example, how people preferred to take their medicines. People's preferences, likes and dislikes were included, this enabled staff to ensure people were happy with the care being provided. Through our observations and discussions with staff they demonstrated an awareness of people's preferences, what people were able to do and what they needed support with. Risk assessments were in place to guide staff on how to minimise the risk of harm to people, these included areas such as medicines amongst others.

We noted people had personal histories in their care plans. A relative told us how they had been able to contribute to providing information about a person's history to the staff. This enabled staff to have a better understanding of who the person was, their experiences and their relationships.

Each person had their care reviewed annually. This took place with the funding authority. People's relatives were invited to attend. We also saw documentation which reviewed the care of people who lacked the mental capacity to make decisions and choices for themselves about the care they were receiving. Family members had been part of a best interest decision making process which involved discussions with them and other relevant parties to ensure the care provided was in the person's best interest. In this way the care provided was centred on each person as an individual, with the aim of meeting their individual needs.

People were encouraged to maintain contact with family members. Relatives were kept up to date with events in the home through telephone calls and visits to the home, and when people visited their family's homes. One relative told us "They phone me up if there is anything at all they need to discuss, they are very good." They had been contacted to see if they wished to go out for lunch with the person, which they were looking forward to.

People participated in activities both in the community and in the home. Some people attended day services, other activities we observed included listening to music and playing indoor bowls. During the inspection people were supported to go out for lunch. Staff told us people enjoyed playing games and doing arts and crafts. Photographs showed people enjoying activities. We were told people also participated in aromatherapy, baking, gardening and going out for walks in the woods.

The home had a complaints policy and procedure. Staff knew how to respond to complaints and who to notify should they receive a complaint. A relative told us they had not had to make a complaint, but they knew how to do so if they needed to. There were no documented complaints and staff were not aware that any had been made.

The provider did not issue questionnaires to people's families or staff to obtain feedback. We understood the provider was in the process of developing a questionnaire that would be used to contact stakeholders to obtain their views on the quality of the service. The findings would be reviewed and an action plan would be

put in place to improve the service to people. Staff told us they could give feedback at any time through supervision or staff meetings.

Is the service well-led?

Our findings

A relative told us the service was well managed, when asked to explain this they told us "Everything always appears to be running smoothly. Everyone seems to get on with each other and they seem to be doing their job ok."

A number of audits had taken place at the home, these included, accidents and incidents, health and safety amongst others. Where accidents had occurred a record of the details was sent to the provider's head office, where staff analysed the data to establish if there were any patterns or if any identified changes to the care were needed.

However, a visiting senior manager completed an audit on a person's care plan in February 2016. They had not identified the issues we found. As a result the care of people was put at risk from inappropriate or poor care. Other audits and checks included checks of fire equipment and regular fire drills. Environmental checks including Legionella had been carried out. The safety of electrical equipment had been completed and each person had a personal emergency evacuation plan in place, this would be used to guide staff on how to manage emergency situations that may affect the running of the home such as flooding.

The service had been through recent changes, because the registered manager was on long term leave and the deputy manager left their post two weeks prior to the inspection. The interim manager had been brought in to oversee the running of the home, whilst managing another service at the same time. Staff were clear that the changes in management had impacted on staff. One staff member told us "It is difficult at the moment, there is no impact for the people living in the home, but it is stressful for staff." We discussed our findings with the interim manager as we went through the inspection. They told us they were surprised at our findings. They told us they intended to spend two days a week in the home to support the staff until the registered manager returned and to rectify the areas we had identified as requiring improvement.

Staff had faith and confidence in the interim manager, who had previously worked in the home. Comments included "X (interim manager) is one of the best, just ring and they will come as soon as possible." Staff also spoke of how they supported each other and how the senior staff were good at their jobs. It was clear from our observations that staff worked well together and there were healthy relationships which focussed on positive outcomes for the people living in the home. There was an open and honest approach by staff, who felt comfortable to raise concerns and speak with the interim manager.

The vision and the values of the staff included comments such as "Providing good staff who work well as a team. The residents are well cared for and appear happy and safe. Providing a nice environment." "We aim to keep the residents safe, keep their independence as much as possible." "When you go home you know you have left them happy, you know you are caring for them in the right way." This matched with the provider's vision of "We help individuals live as independently as possible by providing tailored support to meet their aspirations and goals in life."

The provider has a legal duty to inform the CQC about changes or events that occur at the home. They do

this by sending us notifications. We had received notifications from the provider regarding changes and events at the home.

We recommend that the service review their audit process.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider failed to act in line with the Mental Capacity Act 2005. Regulation 11 (1) (2) (3)
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The provider failed to maintain the property. Regulation 15 (1) (a) (b) (c) (e) (2)
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to maintain records as are necessary to be kept in relation to persons employed in the carrying on of the regulated activity, and the management of the regulated activity. Regulation 17 (2) (d)