Review of compliance

Heathcotes Care Limited Heathcotes (Sawley)	
Region:	East Midlands
Location address:	1 Bradshaw Street Sawley, Long Eaton Nottingham Nottinghamshire NG10 3GT
Type of service:	Care home service without nursing
Date of Publication:	May 2012
Overview of the service:	Heathcotes Care Limited is registered to provide the regulated activity: 'Accommodation for persons who require nursing or personal care' at Heathcoates (Sawley). Heathcoates (Sawley) is a care home for up to 6 people with learning disabilities and autistic spectrum disorders between the ages of 18 to 65.

Summary of our findings
for the essential standards of quality and safety

Our current overall judgement

Heathcotes (Sawley) was not meeting one or more essential standards. Improvements are needed.

The summary below describes why we carried out this review, what we found and any action required.

Why we carried out this review

We carried out this review because concerns were identified in relation to:

Outcome 01 - Respecting and involving people who use services
Outcome 04 - Care and welfare of people who use services
Outcome 07 - Safeguarding people who use services from abuse
Outcome 13 - Staffing
Outcome 16 - Assessing and monitoring the quality of service provision

How we carried out this review

We reviewed all the information we hold about this provider, carried out a visit on 1 November 2011, observed how people were being cared for, looked at records of people who use services, talked to staff, reviewed information from stakeholders and talked to people who use services.

What people told us

We saw a mixed picture of the care provided. We spoke with two people who used services. They both told us they had care plans and they had discussed their care and support needs with staff.

They told us they went out most days of the week, went out shopping, to cafés and pubs during the week and at the weekend. They told us there were regular tenants' meetings where they talked about life at the home.

They told us about the activities they took part in, such as going away on mini breaks with staff members, as support, usually their key worker, and taking part in special community events, such as the yearly bonfire night event. A key worker is a staff member allocated to get to know a person who uses services during their stay, and provides one to one activities to carry out with the person using the service.

People who used services told us they received visitors from their family members and were able to speak with them privately in their bedroom.

One person told us, "I prefer to lock my room door when I am not in it." They showed us

their room key.

Two people told us, "Care provided at the home was given by a number of different support staff." One person explained, "It is better to have the same staff to care for me each time I need help."

However, we found some visitors were unhappy with the care and with communication from staff.
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What we found about the standards we reviewed and how well Heathcotes (Sawley) was meeting them

Outcome 01: People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run

People who use services were supported to make choices within the home and they were treated with respect.

Outcome 04: People should get safe and appropriate care that meets their needs and supports their rights

People who use services did not always experienced effective, safe and appropriate care, treatment and support that met their needs and protected their rights as care was not always provided in a consistent manner and information was not always communicated to

all relevant people in a timely way.

Outcome 07: People should be protected from abuse and staff should respect their human rights

People who use services were protected from abuse, or the risk of abuse, and their human rights were respected and upheld.

Outcome 09: People should be given the medicines they need when they need them, and in a safe way

People who use services had their medicines at the times they needed them and information about the medicine being prescribed was made available to them. However, we found that there were a number of interruptions during medication administration which potentially introduced a risk of distraction that could lead to errors being made.

Outcome 13: There should be enough members of staff to keep people safe and meet their health and welfare needs

People who use services were safe and their health and welfare needs were met by sufficient numbers of appropriate staff.

Outcome 14: Staff should be properly trained and supervised, and have the chance to develop and improve their skills

People who use services were safe and their health and welfare needs were met by competent staff.

Outcome 16: The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care

People who use services benefited from safe care, treatment and support. People's needs were monitored although the communications between staff with family members was not well managed.

Actions we have asked the service to take

We have asked the provider to send us a report within 7 days of them receiving this report, setting out the action they will take to improve. We will check to make sure that the improvements have been made.

Where we have concerns we have a range of enforcement powers we can use to protect the safety and welfare of people who use this service. When we propose to take enforcement action, our decision is open to challenge by a registered person through a variety of internal and external appeal processes. We will publish a further report on any action we have taken.

Other information

Please see previous reports for more information about previous reviews.

What we found for each essential standard of quality and safety we reviewed

The following pages detail our findings and our regulatory judgement for each essential standard and outcome that we reviewed, linked to specific regulated activities where appropriate.

We will have reached one of the following judgements for each essential standard.

Compliant means that people who use services are experiencing the outcomes relating to the essential standard.

A **minor concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard.

A **moderate concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard and there is an impact on their health and wellbeing because of this.

A **major concern** means that people who use services are not experiencing the outcomes relating to this essential standard and are not protected from unsafe or inappropriate care, treatment and support.

Where we identify compliance, no further action is taken. Where we have concerns, the most appropriate action is taken to ensure that the necessary improvements are made. Where there are a number of concerns, we may look at them together to decide the level of action to take.

More information about each of the outcomes can be found in the *Guidance about compliance: Essential standards of quality and safety*

Outcome 01:
Respecting and involving people who use services

What the outcome says

This is what people who use services should expect.

People who use services:
* Understand the care, treatment and support choices available to them.
* Can express their views, so far as they are able to do so, and are involved in making decisions about their care, treatment and support.
* Have their privacy, dignity and independence respected.
* Have their views and experiences taken into account in the way the service is provided and delivered.

What we found

Our judgement

The provider is compliant with Outcome 01: Respecting and involving people who use services

Our findings

What people who use the service experienced and told us
We spoke with two people who used services. They both told us they had care plans and they had discussed their care and support needs with staff.

They told us they went out most days of the week, went out shopping, to cafés and pubs during the week and at the weekend. They told us there were regular tenants' meetings where they talked about life at the home.

They told us about the activities they took part in, such as going away on mini breaks with staff members, as support, usually their key worker, and taking part in special community events, such as the yearly bonfire night event. A key worker is a staff member allocated to get to know a person who uses services during their stay and provides one to one activities to carry out with the person using the service.

One person told us they decided what to wear and what they would have to eat. This person explained they went out to do shopping and would have something to eat when they were out. They explained they got up later at weekends as part of their personal choice and staff respected their decision to do this.

People who used services told us they received visits from their family members and

were able to speak with them privately in their bedroom.

One person told us, "I prefer to lock my room door when I am not in it." They showed us their room key. This person told us they could choose whether they wished to spend time alone or with others and they generally chose not to do planned activities in the evenings. This person also told us they would sometimes prepare their own food.

Two people told us that care provided at the home was given by a number of different support staff. One person explained, "It is better to have the same staff to care for me each time I need help."

Other evidence
We spoke with two people who lived at the home and looked at a third person's care record whose limited verbal communication made it difficult to obtain their views.

We saw people using the service who were encouraged to take control of their lives and were provided with an opportunity to make decisions and choices, supported by the home. We saw that the person who could not communicate verbally was encouraged to use the facilities provided, and staff encouraged them to make use of the sensory room. This was a room with music, dimmed coloured lighting, and soft furnishings decorated to enhance relaxation.

There were daily activity schedules in place for each person. For those attending schools the activities were structured from Monday to Friday with free time at the weekend that was less structured and included visits from family members. Activities were regularly recorded in the care and support plans that we looked at.

People's preferences were shown in different ways. We looked at three bedrooms. The rooms were decorated to their liking and reflected their lifestyle choices. One person was a younger adult with many motor car images in their bedroom and the other person was an older person with aftershave, a flat screen television and music system. This demonstrated the differences between them as part of the diversity within the age ranges and abilities of people living at the home. One bedroom was fairly sparse and had furnishings in it to meet the person's needs. The care plan identified the risks to this person and why furnishings were kept to a minimum.

Each person had a care plan, although involving the person who used services or their family members in the development and review of their plan was variable. Risk assessments were in place and were mainly reactive to situations that arose, and were focused on keeping people using services safe. In one case it was only after an event that the necessary measures were put in to place. Where there were limitations in place, there was some evidence that decisions were agreed with the family on behalf of the person using the services but this was not always consistent.

We saw that all three of the support plans had considered mental capacity issues. Where appropriate, parents were involved in the decision making. We saw that 'Best Interest' assessments were completed as part of the Mental Capacity Act 2005.

These are decisions taken on behalf of the person who uses the service as part of the duties and responsibilities of staff under the Mental Capacity Act 2005. A decision made under this act for or on behalf of a person who lacks capacity must be done, or

made, in their best interests. It must be achieved in the least restrictive way so that the person who uses services still has rights and freedom of action.

Staff that spoke with us demonstrated their levels of awareness about the individual needs and personalities of the people who used the service, for example, with meals and activities. One staff member explained how one person communicated yes with smiles, and indicating no by leaving the room, which was reflected in their care plan. This was achieved by getting to know the person who used services.

Staff told us they respected people's choices by not entering locked bedrooms where people had expressed this. We saw this was written in the care plan.

Our judgement
People who use services were supported to make choices within the home and they were treated with respect.

Outcome 04:
Care and welfare of people who use services

What the outcome says

This is what people who use services should expect.

People who use services:
* Experience effective, safe and appropriate care, treatment and support that meets their needs and protects their rights.

What we found

Our judgement

There are moderate concerns with Outcome 04: Care and welfare of people who use services

Our findings

What people who use the service experienced and told us
One person told us, "I went away on holiday for 4 days with my key worker and we had a nice time." This person also told us, "People living here mostly get on together."

We spoke with one person who told us they had a key worker and they spent time with them.

One person using the service told us; "Care provided at the home is given by a number of different support staff and for some people this is not good for them."

Other evidence
We saw a mixed group of people with varying degrees of ability and communication skills.

Each care plan had identified risks, and explained how these were managed and reviewed. One person had come to the home and had needed a high level of support and supervision by staff. A year later this person's risk assessments indicated they were more settled now. Fewer staff supervised them although the potential for harm continued to be monitored and risk assessed. A chart known as a 'body map' was used to map any bruises, indentifying marks or injuries on the body. In this way injuries or marks could be monitored and recorded.

There were monthly progress reports and six monthly reviews of care plans for one person. We saw regular evidence of social workers and other relevant professionals

involved in planning and providing support.

We saw that when people presented with behavioural problems this was recorded with the agreed management of their behaviour. Measures were then put in place for staff to use as the techniques to reduce these events.

We saw a copy of the policy and procedure on the use of physical interventions in the management of challenging behaviour. Staff were expected to use this when required as appropriate training had been provided. We spoke with one staff member on duty who explained that distraction techniques were used but when restraint was used; the minimum force should be used for a minimum length of time to achieve the goal of attaining a safe situation. The manager told us there were staff who were trained to use physical restraint techniques who worked on each shift. It was not clear who these staff members were on the rota.

Staff confirmed people using the service, received care provided by a number of different support staff when on duty. They were aware this would not always be satisfactory to meet the needs of people with specific conditions who needed to have the same staff to understand their specialist needs.

We saw staff had been asked by one person's relative to use communication training that includes sign language with the person using the service. It was important for the staff to liaise with the school to ensure that they both used the same signs with this person. Six signs had been agreed to ensure consistency between both agencies. Sign language uses hand movements to make signs that convey a message. We asked the staff about the use of signing to the person using the service and they explained that the person had limited ability to use the six signs and responded to just two.

A relative told us they did not have confidence that staff at the home regularly or actively used signing to their relative as when they asked staff to demonstrate it to them they were frequently not able to do so.

We saw that when people were ill appropriate measures were taken to return them to better health by contacting the GP. We saw that people were taken for hospital outpatient appointments when arranged. Other health care professionals were also included in people's healthcare provision.

We spoke with the local authority who explained that they had regular involvement with this care home. They had regular meetings with staff at the home to resolve basic care issues. They found that there were issues around communication. Families were not always kept informed when changes happened as calls were not always made to relatives. They found that record keeping could be improved as information could be more descriptive when included in some care plans. They found that systems were put in to place for staff to follow but staff would alter them without authorisation by the manager to do so. They found that this had an impact on the care provided as continuity of some people's care was disjointed.

A family member complained of similar issues. They explained that for their relative the staff did not appear to have the necessary skills to meet their relative's needs who had profound learning disabilities. They explained that staff were not always aware of the signs for a person who was in pain or distress as staff would accept this as being

challenging behaviour.

Our judgement
People who use services did not always experienced effective, safe and appropriate care, treatment and support that met their needs and protected their rights as care was not always provided in a consistent manner and information was not always communicated to all relevant people in a timely way.

Outcome 07:
Safeguarding people who use services from abuse

What the outcome says

This is what people who use services should expect.

People who use services:
* Are protected from abuse, or the risk of abuse, and their human rights are respected and upheld.

What we found

Our judgement

The provider is compliant with Outcome 07: Safeguarding people who use services from abuse

Our findings

What people who use the service experienced and told us
Two people told us, they felt safe at the home although one person explained they would like a place of their own as they found some people at the home to be too noisy for them.

Other evidence
A copy of the local safeguarding policy and procedure was available to staff at the home.

We spoke with two staff about safeguarding vulnerable adults. They understood their role and what was expected of them. Staff records for training were held on the computer.

We asked to see a full training matrix to confirm that all staff who with vulnerable adults at this service had received training in this area. Safeguarding training for all staff was confirmed.

The Care Quality Commission was not always notified by the provider of some incidents but they were shared with the local authority and dealt with.

Our judgement
People who use services were protected from abuse, or the risk of abuse, and their human rights were respected and upheld.

Outcome 09:
Management of medicines

What the outcome says

This is what people who use services should expect.

People who use services:
* Will have their medicines at the times they need them, and in a safe way.
* Wherever possible will have information about the medicine being prescribed made available to them or others acting on their behalf.

What we found

Our judgement

There are minor concerns with Outcome 09: Management of medicines

Our findings

What people who use the service experienced and told us
We did not observe people or speak to them about this outcome; therefore our judgement has been made on other evidence.

Other evidence
We inspected this outcome as we had received information that raised concerns about a medication error that had taken place. The mistake was due to human error as the systems for checking medications in to and out of the home were in place. The procedure for checking medicines was satisfactory.
We observed a person using the service receiving their medicine. It was given correctly.

When we looked at the medication process at the home, we found that there was no dedicated room for medicines to be administered from. The main office was used for this purpose. We saw that people continually entered and left this area and staff could be easily distracted as a result of this.

This is an area for the provider to review in order to keep people who used services safe at all times when providing them with their medicines.

We saw information leaflets about the medicine being prescribed was made available to people who used services or others acting on their behalf.

Our judgement

People who use services had their medicines at the times they needed them and information about the medicine being prescribed was made available to them. However, we found that there were a number of interruptions during medication administration which potentially introduced a risk of distraction that could lead to errors being made.

Outcome 13:
Staffing

What the outcome says

This is what people who use services should expect.

People who use services:
* Are safe and their health and welfare needs are met by sufficient numbers of appropriate staff.

What we found

Our judgement

The provider is compliant with Outcome 13: Staffing

Our findings

What people who use the service experienced and told us
Two people told us, "Staff were okay with them and supported them."

Other evidence
There were six people living at the home on the day of visit.

We saw a copy of the staff rota. There was usually six or seven staff to support people living at the home and a manager throughout the day. There was two waking staff at night.

We saw staffing levels were as described and matched the staff rota.

We saw people went about their daily business in and outside of the home supported by staff.

Our judgement
People who use services were safe and their health and welfare needs were met by sufficient numbers of appropriate staff.

Outcome 14:
Supporting staff

What the outcome says

This is what people who use services should expect.

People who use services:
* Are safe and their health and welfare needs are met by competent staff.

What we found

Our judgement

The provider is compliant with Outcome 14: Supporting staff

Our findings

What people who use the service experienced and told us
We did not speak to people using services about this outcome; therefore our judgement has been made on other evidence.

Other evidence
This was a home for people with learning disabilities, autism and or challenging behaviour. The staff matrix indicated that people who worked at the home had received training in these areas. This matrix was on a large spreadsheet on the computer and not always easy to read. This matrix on all staff training should be made available in an easy to read printed version. Information about training for staff has been received.

We were told four staff had received communication training that includes sign language and more staff were now using it. There were 20 permanent and six bank staff employed at the home and all staff had received training in the Non Aggressive Psychological and Physiological Intervention technique as a measure to restrain people with challenging behaviours. Three staff had received specialist training for people with autism and /or with challenging behaviour. There were 24 staff who had received training in the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. There were 24 staff who had received training in the Safeguarding of Adults for people with Autism and challenging behaviour. We were told that further training was to take place 31 January 2012 and mandatory training would also be updated in February 2012. Training in communication was booked for early February we have been informed this has taken place.

Our judgement

People who use services were safe and their health and welfare needs were met by competent staff.

Outcome 16:
Assessing and monitoring the quality of service provision

What the outcome says

This is what people who use services should expect.

People who use services:
* Benefit from safe quality care, treatment and support, due to effective decision making and the management of risks to their health, welfare and safety.

What we found

Our judgement

There are minor concerns with Outcome 16: Assessing and monitoring the quality of service provision

Our findings

What people who use the service experienced and told us
We did not observe people or speak to them about this outcome; therefore our judgement has been made on other evidence.

Other evidence
Documentation was available about how to make a complaint. It was available in a format to meet the language and communication skills of the people who used services.

We saw staff meetings were held to discuss issues within the home that would have an impact on the care provided to people who used services.

The company who supplied medicines provided monitoring and assessment visits at the home. Safeguarding incidents were reported to the appropriate authorities.

We saw full audits by the provider took place every six months and an assessment followed from this. A copy of this was provided following our visit. Audits looked at staffing, training, personnel files, care records and choices. The environment and medicines. There was still work in progress to be made by the manager of the home. We read the minutes of a team meeting where staff were reminded to check people's clothes for labels as clothes were allocated to the wrong person. We read how staff were reminded to be more consistent in their approach in various aspects of care including encouraging people to take more fluids each day, to check that certain people ate properly and to make sure that every one was taken out each day or at minimum once a week to do an activity in the community. Medication interruptions had not been

indentified during the quality audits of medicines by the provider although policies and procedures were looked at.

Communication between staff at the home and people's relatives had been raised as an issue for concern and ways to manage this were still needed.

We saw there were monthly visits to monitor care practice and to provide support to the manager at the home. On the day of our visit a senior manager had arrived to perform this.

We saw staff received supervisions on a regular basis with their manager.

Our judgement
People who use services benefited from safe care, treatment and support. People's needs were monitored although the communications between staff with family members was not well managed.

Action
we have asked the provider to take

Compliance actions

The table below shows the essential standards of quality and safety that **are not being met**. Action must be taken to achieve compliance.

Regulated activity	Regulation	Outcome
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 04: Care and welfare of people who use services
	How the regulation is not being met: People who use services did not always experienced effective, safe and appropriate care, treatment and support that met their needs and protected their rights as care was not always provided in a consistent manner and information was not always communicated to all relevant people in a timely way.	
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 09: Management of medicines
	How the regulation is not being met: People who use services had their medicines at the times they needed them and information about the medicine being prescribed was made available to them.	
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 16: Assessing and monitoring the quality of service provision
	How the regulation is not being met: People who use services benefited from safe care, treatment and support. People's needs were monitored although the communications	

	between staff with family members was not well managed.

The provider must send CQC a report that says what action they are going to take to achieve compliance with these essential standards.

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's report should be sent to us within 7 days of the date that the final review of compliance report is sent to them.

Where a provider has already sent us a report about any of the above compliance actions, they do not need to include them in any new report sent to us after this review of compliance.

CQC should be informed in writing when these compliance actions are complete.

What is a review of compliance?

By law, providers of certain adult social care and health care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The Care Quality Commission (CQC) has written guidance about what people who use services should experience when providers are meeting essential standards, called *Guidance about compliance: Essential standards of quality and safety*.

CQC licenses services if they meet essential standards and will constantly monitor whether they continue to do so. We formally review services when we receive information that is of concern and as a result decide we need to check whether a service is still meeting one or more of the essential standards. We also formally review them at least every two years to check whether a service is meeting all of the essential standards in each of their locations. Our reviews include checking all available information and intelligence we hold about a provider. We may seek further information by contacting people who use services, public representative groups and organisations such as other regulators. We may also ask for further information from the provider and carry out a visit with direct observations of care.

When making our judgements about whether services are meeting essential standards, we decide whether we need to take further regulatory action. This might include discussions with the provider about how they could improve. We only use this approach where issues can be resolved quickly, easily and where there is no immediate risk of serious harm to people.

Where we have concerns that providers are not meeting essential standards, or where we judge that they are not going to keep meeting them, we may also set improvement actions or compliance actions, or take enforcement action:

Improvement actions: These are actions a provider should take so that they **maintain** continuous compliance with essential standards. Where a provider is complying with essential standards, but we are concerned that they will not be able to maintain this, we ask them to send us a report describing the improvements they will make to enable them to do so.

Compliance actions: These are actions a provider must take so that they **achieve** compliance with the essential standards. Where a provider is not meeting the essential standards but people are not at immediate risk of serious harm, we ask them to send us a report that says what they will do to make sure they comply. We monitor the implementation of action plans in these reports and, if necessary, take further action to make sure that essential standards are met.

Enforcement action: These are actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers are set out in the law and mean that we can take swift, targeted action where services are failing people.

Information for the reader

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Care Quality Commission

Website	www.cqc.org.uk
Telephone	03000 616161
Email address	enquiries@cqc.org.uk
Postal address	Care Quality Commission Citygate Gallowgate Newcastle upon Tyne NE1 4PA