Inspection Report

We are the regulator: *Our job is to check whether hospitals, care homes and care services are meeting essential standards.*

Heathcotes (Sawley)

1 Bradshaw Street, Sawley, Long Eaton, Nottingham, NG10 3GT

Tel: 01159721376

Date of Inspection: 23 May 2013

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We inspected the following standards as part of a routine inspection. This is what we found:

Consent to care and treatment	✓ Met this standard
Care and welfare of people who use services	✓ Met this standard
Safeguarding people who use services from abuse	✓ Met this standard
Records	✓ Met this standard

Details about this location

Registered Provider	Heathcotes Care Limited
Overview of the service	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.
Type of service	Care home service without nursing
Regulated activity	Accommodation for persons who require nursing or personal care

Contents

When you read this report, you may find it useful to read the sections towards the back called 'About CQC inspections' and 'How we define our judgements'.

Summary of this inspection

Why we carried out this inspection

This was a routine inspection to check that essential standards of quality and safety referred to on the front page were being met. We sometimes describe this as a scheduled inspection.

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 23 May 2013, observed how people were being cared for and checked how people were cared for at each stage of their treatment and care. We talked with people who use the service, talked with staff, reviewed information sent to us by commissioners of services and talked with commissioners of services.

What people told us and what we found

On arrival at the home we saw people were being involved in making decisions about their lives. For some people this involved getting ready to go out with their family members. In this way family relationships were being maintained. For others we saw they were being helped to decide their chosen activity for the day. We saw people were given choices as to how they wished to spend their time. People were assisted to give consent to their care and to their treatment. We spoke with one person who told us they had access to their own records when they, wanted to see them. They told us they regularly kept their own records as part of their right to confidentiality.

During our visit people were seen going out and returning from activities. We saw they looked happy and well cared for.
Two people told us they felt safe living at the home. There were a variety of documents in the foyer to help them if they needed more help or advice.

You can see our judgements on the front page of this report.

More information about the provider

Please see our website www.cqc.org.uk for more information, including our most recent judgements against the essential standards. You can contact us using the telephone number on the back of the report if you have additional questions.

There is a glossary at the back of this report which has definitions for words and phrases we use in the report.

Our judgements for each standard inspected

Consent to care and treatment ✓ Met this standard

Before people are given any examination, care, treatment or support, they should be asked if they agree to it

Our judgement

The provider was meeting this standard.

Before people received any care or treatment they were asked for their consent and the provider acted in accordance with their wishes. Where people did not have the capacity to consent, the provider acted in accordance with legal requirements.

Reasons for our judgement

We selected two people as we had received a couple of notifications of concern about them since our last visit. We saw the provider had considered the mental capacity of both people at the home and had made best interest decisions where necessary. Both people had on going concerns. The provider ensured they both had up to date reviews by their local authorities. In both cases a review had been arranged so that key people in their lives were included. In one case it was determined that the person had capacity and was able to understand the consequences of their behaviour. A contract with guidelines was made between the person and staff at the home. The person had signed to say they agreed to the guidelines and understood why following them would make a positive difference to their lives.

In another example we found alternative methods had been employed to encourage a change to the person's pattern of behaviour. A decision involving other health care professionals had been made to reduce their medication. This was encouraged to help the person become more aware of their surroundings. The expectation was that they could enjoy their life with the minimal use of sedative medications. This had been difficult at first but all concerned were learning to cope with this important change. We met the person and saw they appeared more settled. We saw they were included in decisions made about them. The staff rota was reviewed by the manager. Staff were actively changed around on the rota to ensure this person could be attended to by staff who they liked and got on well with. We saw their needs, likes and preferences were fully documented. The support plans for staff to follow were clearly written.

For one person they had constant supervision by staff. This could be classed as a restriction on them. This person was at risk of self harm. They had unpredictable behaviour and a medical condition that needed to be monitored. Therefore under the Mental Capacity Act 2005 this had been justified. We saw the number of incidents had been reduced and distraction techniques were being used more often. There were no physical interventions for the person during the month of February compared with more

physical interventions during January. When physical interventions were used staff were trained to use an accredited technique and it was documented in the care plan. At the person's review we saw the Mental Capacity Act 2005 Code of Practice had been considered. It allowed for a minimum use of restraint for the shortest possible time to prevent harm. In this way it was not deemed to be a restriction on the person's liberty. The person was shown to have regular visits to their family with support from care workers. We were told these visits were successful. The person was happy to return to the home each time. The family were also happy with this arrangement. The person had the Deprivation of Liberty Safeguard authorisation lifted as a result. Everyone involved in the decision making process were satisfied that this was the right decision for the person. This person was rewarded for positive behaviour. This enabled them to go out more often. Recent records about them indicated their behaviour was improving.

Care and welfare of people who use services ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

People experienced care, treatment and support that met their needs and protected their rights.

Reasons for our judgement

Both care plans included risk assessments for personal safety in the community. This included risks around road safety for each person or risks by other people when out in the community. When at the home risks around personal safety were also included. This could involve personal hygiene risks when using the bathroom. Again the risk assessments were based around people's safety needs. Instructions were provided for the care workers as to what they should do. For example one person usually needed two people when out, but for privacy needs they would have one person with them during bath times. For another it may involve prompting to the next stage of the process or no help at all for certain activities.

We found risk reduction plans were put in to place for different activities with different people. For one person this related to their tendency towards physical violence which could place every one at risk and particularly care workers. A behaviour scale chart was used to reduce the risk. This included receiving appropriate support from care workers. Care workers needed to be able to recognise the signs, follow the ways for reducing the danger from an action becoming out of control. This would be achieved by using the person's risk reduction plan. We saw this information was documented on an antecedent behavioural chart. This was a chart that had information about how the behaviour started, progressed and subsided. A break down of the incidents was sent to the organisations behavioural specialist. The role of the specialist advisor was to analyse the information. In this way they could use the information to help and support staff. When the agreement was being made with a person at the home, the specialist advisor had been involved. They were involved as part of the senior management team. The restraint reduction plan was reviewed to give the person further incentives to stay within the boundaries agreed to.

Care and treatment was planned and delivered in a way that ensured people's safety and welfare. Both care plans were reviewed. The review included relevant people such as a family member or advocate as part of the decision making process. We saw risks took into account people's care and any specialist needs of the person. This was balanced by their independence and choice. Where limitations were made, they were made with the acknowledgement or consent of the person. We saw both people exerted their right to choices. For some people this included not allowing others to see information about them. For another person this included agreeing to have unhealthy food choices less often and accepting some of the limitations placed on them. As part of medication assessment, one

person was assessed to understand aspects of their medication. Appropriate arrangements were put in to place in relation to the recording of their medicine. The person was provided with a copy of their medicine sheet. This was useful should this information be needed for medical reasons when they were away from the home for a length of time. They were prescribed and given their medicines as appropriate.

We found the new manager had made efforts to ensure good practice developments were transferred to daily thinking as part of the way staff worked with people. For example people were encouraged to help around the home. They worked along side staff with the decoration of the home. We saw photographs of them all working together.

Safeguarding people who use services from abuse ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

People who use the service were protected from the risk of abuse, because the provider had taken reasonable steps to identify the possibility of abuse and prevent abuse from happening.

Reasons for our judgement

In the hall way we saw a number of polices around the health and safety of people. Displayed on the notice board was a copy of; the local safeguarding policy and procedure, Every Child Matters, the Safeguarding Framework Guidance May 2012, Winterbourne final government paper and fire safety presented as easy to understand pictures. This was available to people at the home and for care workers.

We spoke with two new care workers about the safeguarding of vulnerable adults. They understood their role and what was expected of them. We saw they had received training in his area as part of their induction to the organisation.

People who use the service were protected against the risk of unlawful or excessive control or restraint because the provider had made suitable arrangements. When physical interventions were used care workers were trained to use an accredited technique. This was known as Non Abusive Psychological and Physical Intervention (NAPPI) to communicate and work effectively with supported people. It was documented in their staff records. In this way people at the home were protected by care workers who were appropriately trained to manage difficult situations or behaviours.

Records ✓ Met this standard

People's personal records, including medical records, should be accurate and kept safe and confidential

Our judgement

The provider was meeting this standard.

People were protected from the risks of unsafe or inappropriate care and treatment.

Reasons for our judgement

People's personal records including medical records were accurate and fit for purpose. Reviews took place yearly. When changes were made and implemented we saw the care plans were reviewed. An incident of missing daily notes was reported to the Care Quality Commission and investigated by the police. The records were not found but the manager assured us there was an increased security of care records. At the end of each shift they were locked away when they were not needed.

Staff records and other records relevant to the management of the services were accurate and fit for purpose. Staff were supported to receive training appropriate for their roles by the provider. The rota was made flexible to meet the needs of people using the service. In this way they could go out and take part in their preferred individual activities in the community. We saw extra training was provided for staff where there was an identified need for them to be able to respond more appropriately to incidents. A senior management visit took place to identify and monitor any changes at the service each month. An action plan was drawn up from this and checked at the next visit. An on call system supported by senior managers was available to staff. In this way support and advice was made available to them when they needed this. We found the records showed there were enough skilled and experienced staff to meet people's needs.

People were made aware of the complaints system as it was displayed near to the entrance of the home. This was provided in a format that could meet the language and communication skills of the people who used the services. There was an effective complaints system available. We found comments and complaints were responded to appropriately. They were stored appropriately and were available for the purposes of an inspection.

Records were kept for the appropriate period of time and then destroyed securely. Staff were provided with a company policy to follow for this.

About CQC inspections

We are the regulator of health and social care in England.

All providers of regulated health and social 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 essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as "government standards".

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of other services less often. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service's records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.

How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

✓ **Met this standard**	This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.
✖ **Action needed**	This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.
✖ **Enforcement action taken**	If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.

How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. Only where there is non compliance with one or more of Regulations 9-24 of the Regulated Activity Regulations, will our report include a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation). This could be a minor, moderate or major impact.

Minor impact – people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

Moderate impact – people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

Major impact – people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.

Glossary of terms we use in this report

Essential standard

The essential standards of quality and safety are described in our *Guidance about compliance: Essential standards of quality and safety*. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the *Guidance about compliance*. The 16 essential standards are:

Respecting and involving people who use services - Outcome 1 (Regulation 17)
Consent to care and treatment - Outcome 2 (Regulation 18)
Care and welfare of people who use services - Outcome 4 (Regulation 9)
Meeting Nutritional Needs - Outcome 5 (Regulation 14)
Cooperating with other providers - Outcome 6 (Regulation 24)
Safeguarding people who use services from abuse - Outcome 7 (Regulation 11)
Cleanliness and infection control - Outcome 8 (Regulation 12)
Management of medicines - Outcome 9 (Regulation 13)
Safety and suitability of premises - Outcome 10 (Regulation 15)
Safety, availability and suitability of equipment - Outcome 11 (Regulation 16)
Requirements relating to workers - Outcome 12 (Regulation 21)
Staffing - Outcome 13 (Regulation 22)
Supporting Staff - Outcome 14 (Regulation 23)
Assessing and monitoring the quality of service provision - Outcome 16 (Regulation 10)
Complaints - Outcome 17 (Regulation 19)
Records - Outcome 21 (Regulation 20)

Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.

Glossary of terms we use in this report (continued)

(Registered) Provider

There are several legal terms relating to the providers of services. These include registered person, service provider and registered manager. The term 'provider' means anyone with a legal responsibility for ensuring that the requirements of the law are carried out. On our website we often refer to providers as a 'service'.

Regulations

We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

Responsive inspection

This is carried out at any time in relation to identified concerns.

Routine inspection

This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.

Themed inspection

This is targeted to look at specific standards, sectors or types of care.

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