Heathcotes Care Limited

Heathcotes (Salford)

Inspection report

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22 May 2019

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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?	Good

Summary of findings

Overall summary

About the service:
Heathcotes (Salford) is a residential care home that provides accommodation and personal care for up to seven people living with learning disabilities and autism. At the time of our inspection there were six people living at the service. This is one of many locations that the provider operates nationally.

People's experience of using this service:
People's outcomes were consistently good, and people's feedback confirmed this. One person told us, "I like it here."

People had detailed person-centred care plans with reference to people's diets, their likes, dislikes and what works well for them. People had 'development plans' which celebrated key achievements and looked at future goals.

We observed positive interactions between staff and people. Staff had good relationships with people and were seen to be caring and respectful towards people and their wishes.

Medicines systems were organised and people were receiving their medicines when they should. The service was following safe protocols for the administration of medicines.

The registered manager followed governance systems which provided effective oversight and monitoring of the service.

The service was well led. The registered manager promoted best practice in person-centred care. There was a clear culture based on achieving positive outcomes for people.

The service met the characteristics of Good in all areas; more information is in the full report.

Rating at last inspection:
At the last focused inspection the service was rated Good overall and Requires Improvement in the Well-led domain (report published 21 September 2018). Following this comprehensive inspection, the overall rating remains unchanged, and all domains are rated Good.

Why we inspected:
This was a planned inspection based on the rating at the last inspection.

Follow up:
We will continue to monitor information and intelligence we receive about the service to ensure good quality care and support is provided to people. We will re-inspect in line with our inspection timescales.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Details are in our Safe findings below.

Is the service effective?

Good

The service was effective.

Details are in our Effective findings below.

Is the service caring?

Good

The service was caring.

Details are in our Caring findings below.

Is the service responsive?

Good

The service was responsive.

Details are in our Responsive findings below.

Is the service well-led?

Good

The service was well-led.

Details are in our Well-Led findings below.

Heathcotes (Salford)

Detailed findings

Background to this inspection

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

Inspection team:
One adult social care inspector carried out the site inspection on both days.

Service and service type:
Heathcotes (Salford) is a residential 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection. Accommodation is provided in a large detached property, over three floors, in single en-suite rooms. There were two communal lounges, a large dining kitchen, utility areas and a garden.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection:
This inspection was unannounced on the first day we visited.
We carried out the site visit of the inspection on 21 May 2019 and 22 May 2019.

What we did:
We reviewed information we had received about the service since the last inspection in September 2018. This included details about incidents the provider must notify us about, such as abuse. We contacted the local authority safeguarding and commissioning teams to gather information about the service. We had requested the service to complete a provider information return (PIR) which we received; this is a form that asks the provider to give us some key information about the service, what the service does well and improvements they plan to make. We used all this information to plan our inspection.

During the inspection, we spoke with all six people who used the service to ask about their experiences of the care provided. We also spoke with the registered manager, regional manager and six staff members, including team leaders and support workers.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who struggled to talk with us fully about their experiences of the care provided. We reviewed a range of records including three people's care records, risk assessments and medication administration records (MARs). We also looked at three staff personnel files around staff recruitment, training and supervision records. In addition, we reviewed records relating to the management of the service, audits, and a variety of policies and procedures developed and implemented by the provider.

Good

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm

People were safe and protected from avoidable harm. Legal requirements were met.

Systems and processes to safeguard people from the risk of abuse
• People were protected from the risks of abuse and harm.
• We saw safeguarding information displayed in the building, which included details of how to recognise abuse.
• There was a safeguarding policy in place. The service followed safeguarding procedures and made referrals to the local authority, as well as notifying the CQC as required.
• Staff received appropriate safeguarding training and refresher courses.
• Staff we spoke with had a good understanding of their responsibilities and how to safeguard people. One staff member said, "I would report concerns to the team leader or the manager. If needed, I would go higher to the regional manager or the CQC."
• There was a whistleblowing policy in place. We spoke with staff about their understanding of this policy and they told us they were aware of the whistleblowing policy.

Assessing risk, safety monitoring and management
• People told us they felt safe living in the home. One person commented, "I feel safe here."
• People had pre-admission assessments known as a 'placement proposal' before they moved into the service. This meant the service knew that they could cater for the person's care needs and the environment was suitable.
• Care plans included risk assessments in relation to people's specific care needs. The risk assessments were person-centred and covered areas such as nutrition, behaviours that challenge and road skills. Positive risk taking was also documented and risk assessed.
• People's ongoing risk assessments were reviewed as part of their care plan reviews, or when needs changed.
• The provider had a physical intervention policy and staff were trained in non-abusive psychological and physical intervention (NAPPI). People had individual risk assessments to physical interventions. One staff member told us, "Verbal redirection is promoted first. Even if someone is physical, we would redirect first. Physical intervention is only used as a last resort."
• A fire risk assessment was in place. People also had Personal Emergency Evacuation Plans (PEEPs) which were specific to their individual needs to ensure their safety in the event of an evacuation.
• Premises risk assessments and health and safety assessments was reviewed on a regular basis, which included gas, electrical safety and fire equipment.

Staffing and recruitment
• We looked at three staff personnel files and we saw robust recruitment procedures. All potential staff were required to complete an application form, and attend an interview so that their knowledge, skills and values could be assessed.

• The provider undertook checks on new staff before they started work. This included obtaining at least two references from previous employers and Disclosure and Barring Service (DBS) checks. The DBS helps employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable people.
• Staff rotas we saw confirmed staffing levels remained consistent, so that people continued to receive continuity in their support.
• Staff worked waking night shifts and the provider operated an on-call system which was covered by the managers. Staff were able to contact on-call for support or advice if needed. One staff member told us, "When working night shifts, I would ring on-call if there was a problem. I have used on-call before, and it is helpful. They [managers] guide us in the right direction."

Preventing and controlling infection
• The home was clean and free from malodour. Staff encouraged and supported people to tidy and maintain their own rooms.
• Records showed environmental audits took place monthly which meant the provider had processes in place to prevent and control infection.
• We saw personal protective equipment (PPE) readily available and accessible, such as disposable gloves and aprons.
• Staff received training in the management of infection control and food hygiene.
• The local authority conducted an infection control audit in March 2019 and issued a rating of 100% with no recommendations.

Using medicines safely
• Medicines were stored, administered and disposed of safely.
• We saw that all staff who administered medicines had the relevant training.
• Records showed staff were up to date with medicines training and staff received regular competency checks.
• Medication administration records (MARs) were up to date and medicine stock counts were accurate. Medicine errors were minimal.
• There were protocols in place for 'as required' (PRN) medicines such as pain relief medicines.
• Regular daily audits of medicines took place which ensured medicines were managed safely.

Learning lessons when things go wrong
• The provider had an accidents and incidents policy to facilitate the analysis of incidents and accidents.
• Accidents and incidents were recorded and monitored by the registered manager for patterns and trends. We saw that when something had gone wrong, the registered manager had responded to this appropriately. For example, when a person had reoccurring behaviours that challenged, they were referred to healthcare professionals or their allocated mental health workers were contacted for support.
• Risk assessments were reviewed following incidents to ensure the service was meeting the needs of people appropriately.

Good

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence

People's outcomes were consistently good, and people's feedback confirmed this.

Adapting service, design, decoration to meet people's needs; assessing people's needs and choices; delivering care in line with standards, guidance and the law
• The home was clean and well maintained. There was sufficient space inside and outside for people to make use of. We observed a relaxed atmosphere throughout the home and saw people making use of all the communal areas.
• We saw communal areas were decorated with artwork created by people who lived there. However, there was a lack of personalisation in people's rooms. The registered manager and staff told us there was a drive to encourage people to personalise their rooms and have them individually decorated to their preferences. One person told us, "I haven't painted my room yet. I have chosen the colours I want." A staff member informed us, "We have had meetings about encouraging service users to personalise their rooms. We have supported people to buy posters of what they like to hang in their rooms. Some service users have chosen paint colours to decorate their rooms, whilst others don't want any paint on." The registered manager commented, "They [people] have the option to choose wallpaper too."
• People's needs were comprehensively assessed and regularly reviewed which meant people continued to receive support that was appropriate to their needs.
• People's preferences, likes and dislikes were acknowledged and recorded.
• People were involved in their care planning. For example, we saw 'development plans' in place which documented the skills people have learnt and goals people would like to work towards. People were responsible for setting their own goals and staff supported people to achieve them. The achievements made were recorded and celebrated.

Staff working with other agencies to provide consistent, effective, timely care; supporting people to live healthier lives, access healthcare services and support
• People had access to community based health services when required and staff supported people with arranging healthcare appointments. Records showed the service worked with agencies to promote people's health, such as dieticians, podiatrists and general practitioners (GPs).
• We saw the service referred people to other professionals including the complex care team and specialist learning disability commissioners when required.
• Information was available to other agencies if people needed to access other services such as GPs, health services and social services. MARs and health passports (documentation that details people's health needs and contains other useful information) were used.

Supporting people to eat and drink enough to maintain a balanced diet
• People's dietary needs and preferences were met, and people were involved in creating weekly meal plans and choosing their meals. We saw meal plans displayed in the kitchen informing people of the foods they

had chosen each week. One person told us, "I like the food here." Another person said, "If I don't like the meal, they [staff] would make me something else."
• During the inspection we observed the lunchtime meals. There was a calm atmosphere and people chose when they would eat their meal and where. Staff were available to provide any assistance to people. People were encouraged to make their own lunch and drinks.
• Snacks and drinks were readily available, and we saw people help themselves. One person told us, "I can get snacks and drinks when I want. I can make my own hot drinks."
• We saw 'healthy eating' was promoted and 'eating well' guidelines were displayed. People were supported to lose weight through their diets as agreed on their care plans.

Ensuring consent to care and treatment in line with law and guidance
• 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 with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).
• We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.
• Staff received training in MCA and DoLS. We observed staff understood consent, the principles of decision-making, mental capacity and deprivation of people's liberty. One staff member told us, "We understand what MCA is. It is about assessing abilities and supporting service users in the correct way for their needs to be met ."
• Capacity assessments were in place where people lacked capacity. Best interest decisions were appropriately recorded and DoLS were being adhered to.
• Records showed people, or their representatives signed to consent for their care and treatment.

Staff support: induction, training, skills and experience
• Staff received induction, training, observations and ongoing supervision to help enable them to be effective in their role. A staff member told us, "There is always ongoing training and refresher training which is brilliant." A second staff member commented, "The induction and training was enough. The refresher training is ideal too. We can pick up on new ideas whilst training with other people."
• New staff were given time to work alongside experienced staff to enable them to familiarise themselves with people's needs.
• Staff knowledge was tested through regular skills test which covered various topics, such as food hygiene, dignity and MCA. Any gaps in knowledge were recorded and followed up.
• Staff felt supported and received regular supervision and opportunities for appraisal. One staff member told us, "I had my appraisal recently and I get regular supervisions every three months, which is helpful. We can discuss what we want."

Good

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect

People were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; equality and diversity
• We observed positive interactions between staff and people. Staff had good relationships with people and were seen to be caring and respectful towards people and their wishes. Staff knew people well and engaged with them by discussing topics that were of interest to the people being supported.
• People were observed to be treated with kindness and were positive about the staff's caring attitude.
• People told us staff were kind. One person said, "They [staff] treat me good." Another person commented, "They [staff] treat me nicely and kindly."
• Equality and diversity was promoted. For example, information was provided to people in the service user guide, which informed people the service was committed to valuing and embracing diversity. The provider also employed staff with protected characteristics. These staff members told us they felt supported.
• Staff had received training in equality and diversity and they were committed to ensuring people had equal opportunities. One staff member told us, "We treat everyone the same regardless of their cultural background. We take into account their care plan and how they do things differently."

Supporting people to express their views and be involved in making decisions about their care
• Staff supported people in a way that allowed people to have control over their lives and make day to day decisions. For example, we saw staff asking people questions and giving them choices about what they would like to do for the day if they diverted from their activity plan.
• People were involved in making choices about their care. One staff member said, "Certain service users prefer female workers and that is accommodated." We also saw records of care planning which documented long term care decisions. For example, people had decided to move placements as part of their long term goal and people were supported to achieve this.
• Records showed people who used the service and relatives were involved in care planning and reviews.
• The service had built connections with advocacy organisations and information regarding this was available for people. Advocacy is a process for supporting people to express their views and concerns.

Respecting and promoting people's privacy, dignity and independence
• We observed staff treat people with dignity and respect and provided support in an individualised way.
• People's right to privacy and dignity was respected. One person told us, "They [staff] treat me with respect." A second person said, "They [staff] respect me and my privacy. They always knock [before entering person's room]."
• Staff we spoke with gave examples about how they respected people's privacy. One staff member told us, "We promote privacy and dignity. We administer creams in a closed room. We knock before entering a service user's room and gain their permission to enter."
• People's independence was promoted. Staff gave us examples about how they involved people doing

certain aspects of their day to day activities which supported them to maintain their independence. One staff member told us, "We encourage service users to do their own tasks. We encourage personal care daily. We encourage people to tidy their own rooms. We support them, but they are encouraged to do their own." Another staff member added, "I would recommend this home to a relative as they would get a lot of support, inside and in the community. People are involved in all activities and they are encouraged to do things for themselves."

Good

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs

People's needs were met through good organisation and delivery.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control
• Holistic assessments and care plans had been completed which reflected the person's needs, wishes and preferences.
• Cultural and religious preferences had been recorded which ensured the service was aware of how people's cultural and religious needs should be met. One staff member told us, "We have service users with different cultural and religious needs, and we support them with their religious activities."
• Regular reviews ensured people had been involved in updating their care plans if they wished to be. A staff member commented, "The team leaders do the reviews, but we provide insight. If there is anything we can add, we do. The manager always gives us the opportunity to add to the reviews. Family are also involved in the reviews depending on how involved they are."
• People participated in activities that met their individual choices and preferences. We found people had a say in the type of activities and trips planned, and observed people engaging and enjoying the activities they took part in. One person told us, I like to take part in [type of activity]. I have told them [staff] and this has been arranged. I have been a few times."
• We saw people's preferences in activities were recorded in their care plans. All people had the right level of support to enable them to access the community and engage in activities.
• The accessible information standard (AIS) was introduced by government to ensure people with disabilities received information in ways which were accessible for them. We found the provider had met this standard. The service had made information available in different formats upon request or where there was an identified need for this. We saw easy read formats of various policies and information displayed throughout the home.

Improving care quality in response to complaints or concerns
• Processes, forms and policies were in place for recording and investigating complaints. There was a satisfactory complaints policy which was also displayed in the building. Complaints were minimal and were logged and responded to as per the complaints policy.
• People had access to a 'service user guide' which detailed how they could make a complaint and who to contact if people were not satisfied with the response.
• People we spoke with were aware of how to make a complaint. One person said, "If I wanted to make a complaint, I would speak to the staff." Another person told us, "If I wanted to complain, I would write a letter to the manager."
• The service had received compliments from people who used the service. One compliment stated, "I have no bad comments. I like everything here."

End of life care and support
• The service did not routinely provide end of life care. There was a policy which outlined how people at the

end of their lives could be supported to consider their wishes and needs. Those people who chose to make their end of life wishes known had the option to document this in their care files. The registered manager told us staff did not receive end of life training, however they did have access to training should the need arise.

Good

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture

The service was consistently managed and well-led. Leaders and the culture they created promoted high-quality, person-centred care.

At our last focused inspection (published in 21 September 2018) we rated this question as requires improvement. This was because although the service was no longer in breach of regulations in relation to Governance, we did not fully review the key question, 'Is the service well led'. At this inspection we found processes within the service had changed to make them more robust and the home was well-led. This domain has now been rated as good.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

• A person we spoke with told us, "[Registered manager name] is the best manager we have ever had. I never want [registered manager name] to leave."

• A commissioner who worked with the service wrote, "Well managed and positive interventions have been made since you [registered manager] took on the managers role. A clearly complex situation but you [registered manager] have been able to offer reassurance and support to [service user name] which has enabled them to be more settled in their home."

• Staff understood their roles and responsibilities. They felt confident to whistle blow and report poor practice if they needed to.

• The management team had regular contact with members of staff each week. Staff said they felt well supported and respected. One member of staff we spoke with said, "The manager is very supportive. If there are any concerns [registered manager name] will act upon it. There is an open door policy and [registered manager name] is supportive when working with the service users. [Registered manager name] is always on the floor helping us and guiding us."

• The registered manager had changed processes within the service to make them more robust. For example, staff had been re-educated about documenting medical appointments and processes associated with such tasks were strengthened.

• The provider and registered manager followed governance systems which provided effective oversight and monitoring of the service. For example, the registered manager carried out regular audits. The regional manager also conducted a monthly quality compliance check.

• At this inspection we saw that the rating from our last inspection was displayed in the building and on the provider's website.

Planning and promoting person-centred, high-quality care and support; and how the provider understands and acts on duty of candour responsibility

• The registered manager promoted best practice in person-centred care. There was a clear culture based on achieving positive outcomes for people. The registered manager received regular support from the wider

management team.
• The provider had a statement of purpose. This clearly set out the aims, objectives and ethos of the service.
• The service had submitted all relevant statutory notifications to us promptly. For example, details about incidents the provider must notify us about, such as abuse. This ensured we could effectively monitor the service between our inspections.
• A good range of audits was used by the service to measure health, safety, welfare and people's needs, which meant the service could evaluate if people's needs were being met appropriately.
• The service had a policy and an understanding of their responsibility of duty of candour. Duty of candour is to ensure that providers are open and transparent with people who use services and other 'relevant persons' (people acting lawfully on their behalf) in general in relation to care and treatment.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; continuous learning and improving care
• There was a positive workplace culture at the service. It was evident staff worked well together, and there was a shared spirit of providing a good quality service to people. One staff member told us, "I enjoy working here. The team is good. This is a good place now that everything is in order with the new manager and secure staff."
• People and their relatives' views had been sought through regular contact, surveys and quality monitoring. These were analysed and any negative comments were acted upon.
• Staff and stakeholder surveys took place annually to monitor and improve the quality of service.
• Monthly residents meetings took place where people had the opportunity to express what they thought about their home and whether anything could be improved. We saw minutes which showed these were well attended.
• Regular staff meetings were held which discussed people and their needs.
• Monthly regional management meetings were held which identified any issues within services and ways to improve quality.

Working in partnership with others
• The service worked in partnership with the local community, other services and organisations such as the local authority. There was a good working relationship with commissioners and health staff to ensure that the people they supported received appropriate and timely care. This showed a multi-disciplinary approach had been taken to support the care of people receiving the service. A commissioner who worked with the service wrote, "Regular updates and good communication is maintained which helps."
• Records showed multi-disciplinary teams were involved in people's care. For example, social workers. This showed a multi-disciplinary approach had been taken to support the care of people receiving the service.