Federation of Jewish Services

The Heathlands Village

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

This inspection took place on 31 May 2017 and was announced. The provider was given 24 hours' notice because we needed to be sure that we were able to speak with the providers of the service who were registered with the Care Quality Commission (CQC).

This inspection was prompted by information we received about an incident following which a person using the service later died. This incident was subject to a police investigation and as a result, this inspection did not examine the circumstances of the incident. However, the information shared with CQC indicated potential concerns about how the service managed the risks of falls when moving and handling people using lifting equipment such as a hoist.

This report only covers our findings in relation to these concerns. The concerns raised form part of the two domains; is the service safe and is the service well led. Our findings are reported under these domains.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for 'The Heathlands Village' on our website at www.cqc.org.uk.

The Heathlands Village provides a wide range of care services for up to 214 older people from both the Jewish and Non–Jewish community. The Heathlands Village is divided into six units and is situated in extensive well maintained grounds. It is close to the village of Prestwich and there is easy access to local shops, public transport and the motorway network.

At the time of our inspection, 129 were using the service and of those 33 people were being transferred by the use of a hoist or a stand aid.

There was a registered manager in place and they were available throughout this inspection. 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.

There were discrepancies between the policy and procedure in relation to the frequency of moving and handling people refresher training and the certificate validation, which was addressed following our inspection.

Care records, risk assessments and systems were in place to help direct staff to use the correct hoist and sling that people had been assessed to use.

Staff had received the moving and handling training they needed to help ensure the safe transfer of people. Refresher moving and handling people training was available and the majority of staff had undertaken this

training. Competence checks were undertaken to check that staff practice was safe; however, there was no centralised system to enable us to confirm which staff had been assessed. We recommend that a central log of competency checks is maintained to help ensure and track that these important checks have been carried out.

Systems were in place to ensure that lifting equipment was maintained as specified by the legal requirements of the lifting operations and lifting equipment regulations (LOLER).

The registered provider had invested in a dedicated moving and handling people training room. The room and equipment cost over £6,000 and was set up in January 2017. A wide range of equipment was seen to have been made available for staff to use for moving and handling training purposes.

The service, where able, had followed the principles of the Duty of Candour, following the incident. The Duty of Candour sets out some specific requirements that providers must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology.

The provider had taken prompt action to help prevent a similar incident occurring. The board had commissioned an independent external advisor to undertake a root cause analysis of the incident.

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.

Care records, risk assessments and systems were in place to help direct staff to use the correct hoist and sling that people had been assessed to use.

All staff received moving and handling people training before they transferred a person by use of a hoist to help ensure the person's safety. The majority of staff had received the moving and handling refresher training they needed to help ensure they maintained safe practice.

Competence checks were also undertaken. However, there was no central record to confirm which staff had undertaken a competence check.

Arrangements were in place to ensure that lifting equipment was maintained in line with the law.

Is the service well-led?

Good

The service was well led.

There were discrepancies between the policy and procedure in relation to the frequency of moving and handling people refresher training which was addressed following our inspection.

The registered provider had invested in a dedicated moving and handling people training room for staff to use.

The provider had taken prompt action to help prevent a reoccurrence of this type of incident.

The service, where able, had followed the principles of the Duty of Candour; this aims to ensure that providers are open and transparent with people who use services and other 'relevant persons'.

The Heathlands Village

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 checked 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 31 May 2017 and was announced. This was so that we could be sure that the nominated individual for the registered provider and the registered manager were present. One adult social care inspector undertook this inspection.

At the inspection, we spoke with the chief executive officer (CEO) for the service who is registered with us as the nominated individual and the director of clinical services who is the registered manager. We also spoke with the quality assurance and development manager and the operations manager who oversees the health and safety arrangements on the site under the director of operations.

We reviewed the policy and procedure for moving and handling people, training arrangements for staff involved in moving and handling people, equipment checks, and five people's care records who were transferred by the use of lifting equipment. We also looked at the duty of candour, which looks at action taken by the provider following incidents to help prevent them happening again and systems in place for monitoring health and safety. We visited five units across the site and spoke to staff in charge at the time to talk through the arrangements in place for the use of moving and handling slings on the units.

Good

Is the service safe?

Our findings

We looked at what action the registered provider took to ensure that staff providing care or treatment to people who used the service had the qualifications, competence, skills and experience to do so safely in relation to the moving and handling of people. We also looked at what information was available to guide staff through a person's transfer using lifting equipment and arrangements for checking lifting equipment.

We saw records that identified all the people at Heathlands that used a hoist or a stand aid. We looked at the care plans, the care plan summary, risk plans and risk assessments of five people who used the service, who were transferred by use of a hoist or stand aid. This was to check whether all reasonably practical action was being undertaken to minimise any risks and how this was recorded. A care plan is written information that sets out a person's care and support needs and how they will be met. A risk assessment is written information about how a person's health, safety and wellbeing will be managed and risks mitigated. The care plans, risk plans and risk assessments we looked at were held on an electronic record system and were printed off for us to view.

We were told that people had their own individual slings and shower slings where appropriate. The registered manager told us that the service employed an external physiotherapist who carried out the assessments to ensure that people had a sling that was the correct fitting for the person's height and weight. However, this information could not be clearly evidenced on people's care and risk plans we saw.

We were told and saw on the care records we saw that it was the responsibility of staff members involved in the transfers of people to check that the sling was fit for purpose before it was used. For infection prevention and control, some slings were regularly sent to the main laundry for washing. This meant that there was movement of slings between the person's room and the site laundry. The provider had recently updated the sling audit and a sling tracker form had been introduced and was being used at handover so that staff knew where people's individual slings were on the site. This helped to ensure staff had the correct equipment available to them in order to support people to transfer safely.

We saw on the records we reviewed that the care plan had a section about people's mobility; this gave guidance to staff about what action they were to take to support the person safely. The care plan included the use of a hoist in the risk plan section of the plan. There were also three assessments that referred to mobility and moving and handling; these included a care needs assessment, a moving and handing needs assessment and a moving and handling assessment. We also saw physiotherapy notes for some people that gave details about the support they had given to people.

We saw on the plans that people were encouraged to retain as much of their mobility as possible. One of the people's records that we saw showed that the person had recently spent time in hospital. The use of a hoist was seen as a temporary measure until the person had regained their muscle tone and strength to move independently again. We saw the physiotherapist had recently reviewed and increased the size of the sling for the person's comfort and that the care plan had been updated to reflect the change. This helped to ensure the person's safety and comfort.

We saw that the records made reference to the type and size of sling to be used and the numbers of staff to be involved in the transfer procedure. The records in some cases referred to the provider's moving and handling training. They also referred to the need for staff to reassure people throughout the transfer process to reduce their anxiety.

We reviewed five people's care records. We saw that an assessment was carried out when the person was admitted to the service to determine their moving and handling support needs. On one file we saw that the person was to be transferred by the use of a sling. We noted that in the person's care plan it stated that the person used a medium sling and in the risk plan a large sling. We checked with staff what size sling this person used and we were satisfied that systems were in place in the person's bedroom to direct staff to identify and use the person's assessed size sling and to check it was fit for purpose.

When we looked at the rooms of those people whose care records we reviewed to see what arrangements were in place in relation to slings we found that people's slings were kept hung up in their en suite bathroom. There was a sign on the back of the door that stated in large letters what sling the staff should use and a checklist that staff had to complete before use to confirm that the sling was in good working order. Staff we spoke with showed us a copy of the recording sheet used and the sling handover sheet to help ensure that the right sling was being used.

We were told that staff, when weighing people, should use the person's identified individual sling. The service used the same type of hoist used in their normal moving and handling transfers that had a digital scale attached.

The quality assurance and development manager told us that when a new social care worker started work at the service, they received an induction folder. We saw that the induction folder included the service's code of conduct, which referred to the health and safety procedures and information about the health and safety committee. Information about health and safety was also included in a moving and handling disclaimer. This is where the social care worker signed their agreement not to carry out any moving and handling of people or loads without the supervision of their mentor or other trained member of staff until such time as they had attended the provider's training and had been deemed competent by their line manager. The quality assurance and development manager told us that the service did not accept training in moving and handling people carried out in a previous role because they could not be sure of the standard of training.

New social care workers receive induction training and were assigned a mentor. Mentoring is a worked based method of training using existing experienced staff to support new staff. In the induction folder, there was also a mentor checklist that staff worked through. There was a session on the third day of the new social care worker's induction on moving and handling people.

All employee job descriptions and person specifications made reference to health and safety. Staff were subject to the Health and Safety at Work Act 1974 and undertook duties and responsibilities in full accordance with the organisation's health and safety policies.

We saw that the service worked in partnership with an independent training provider who delivered the moving and handling people training and had done so since 2011. The service had a record of the trainer's certificates to check this person was suitably qualified to carry out the training to staff. This included a postgraduate diploma in occupational safety and health, education and training to BA Hons standard and a graduate of the institute of safety and health (IOSH).

The service had recently worked in partnership with the training provider to create a new training room that replicated a bedroom used by people. We saw that there was a range of moving and handling people equipment staff could practice with, for example, glide sheets and boards. A life size model had also been purchased. The model could be adapted to replicate people's support needs, for example where pressure area care or muscle contraction may need to be considered by staff when using a sling and a hoist.

We saw that manual handling training was included in the induction health and safety training day, which all staff at Heathlands regardless of their role were required to complete. We saw a copy of the 'expresso' (induction) training presentation. This included information about the legislation such as manual handling operations, the provision and use of work equipment and the lifting operations and lifting equipment regulations (LOLER).

We saw that staff responsible for moving and handling people then received a further one day training. The course content included an overview of the legislation relating to manual handling, the role of risk assessments, implementation and supervision, principles of good back care, safety issues, identification of incorrect techniques, basic lifting and carrying, sit to stand/stand to sit, assisted walking and safe use of equipment. A certificate of training was produced on successful completion of the course with a recommended update of the course after 12 months.

We saw that there was a training schedule in place for 2017. We saw that training in the moving and handling of people induction and refresher training had taken place in January, March, April and May 2017 and was planned for June July September and November 2017. We saw that the availability of training in moving and handling people was also advertised on the staff noticeboard. The poster clearly advised staff that if they assisted in the moving and handling of people and had not attended a within 12 – 18 months, staff should be attending this course. The frequency of refresher training contradicted the services policy and procedure, which stated staff should receive updated training annually and the initial training certificate, which stated a recommended update of the course after 12 months.

We saw the staff training record for the moving and handling of people. This record showed that 145 staff had received refresher training in moving and handling people. Twenty four staff were booked on a refresher course in June 2017. We noted that the refresher training for three staff members training was overdue. We saw on the staff training record that in one case this had been followed up with the person's line manager. Following our inspection the provider confirmed that of the other two staff one was on maternity leave and the other had been suspended therefore they were not available for duty or training.

All staff who had completed moving and handling people training received a book entitled 'Safe moving of objects and people'. This is a detailed, visual, easy to understand guide covering the important manual handling principles when moving objects and people. This included a section on the use of slings and hoists. Staff were also asked to complete training evaluation forms on completion of the training. We saw copies of the forms which gave positive feedback about the training they received.

We saw information that observations of staff's practices were carried out on the units to check staff competence. We were told that this took place three times a year or more frequently if due a refresher or any concerns raised. We saw the record of staff competency checks completed for March 2017 and that arrangements were in place for the trainer to return in June 2017. Records also showed which staff were responsible for assessing the health and safety competencies of staff on their unit. We saw a copy of the assessment of competency, which included a question about what specific training was required before a staff member could carry out moving and handling of a resident. However, there was no central log kept of when these assessments had been carried out with staff so we could not be sure which staff had received a

competency check.

We recommend that a central log of competency checks is maintained to help ensure and track that these important checks have been carried out.

We saw a copy of the Care Certificate Standard 13 health and safety, which included an assessment of the staff member's competence, without prompt, in a transfer using a mobile hoist and a standing hoist. The Care Certificate is a set of standards that social care and health workers follow in their daily working life and are the minimum standards that should be covered as part of induction training for new care workers.

Each unit had an identified health and safety champion who reported to the operations directorate and the health and safety committee. These staff received additional training to carry out this role and undertook monthly health and safety audits of the unit they were assigned to.

We looked at what measures were in place to ensure that equipment used in the moving and handling of people was safe to use and used in a safe way.

We asked if there had been any accidents and incidents, which involved the use of a hoist. We used 2011, the year training started with the current training provider, as a timeline. We were informed that there had been two incidents involving a hoist during the timeframe. One was a manufacturing fault to a new hoist and we saw a copy of the manufacturer's report to confirm this dated 18.10.2016. The registered manager informed us of a second incident, which involved a wrongly placed strap that had resulted in minor bruising of a person. This incident happened on 24 July 2015.

We were told about the servicing and maintenance arrangements for lifting equipment. The operations manager showed us the audit they maintained to keep track of the arrangements for slings and hoists. This was to help ensure that equipment complied with LOLER.

Good

Is the service well-led?

Our findings

We looked at what systems were in place to assess, monitor and mitigate the risks relating to the health safety and welfare of people who used the service.

We saw that the registered provider had invested in a dedicated moving and handling people training room. The room and equipment cost over £6,000 and was set up in January 2017. A wide range of equipment was seen to have been made available for staff to use for moving and handling training purposes.

We saw information that showed that there were health and safety champions in place across the site who carried out audits on the units or areas they were responsible for. The health and safety champions carried out monthly audits and attended health and safety champions meetings. We saw a copy of the minutes of a meeting held on 16 may 2017 that discussed issues raised through these audits.

At this meeting, it was discussed about the importance of having up to date information about how to handle and move people. The operations manager was to send champions a copy of the moving and handling people policy and discussed the importance of checking and recording the use of equipment to ensure it was fit for purpose. We also saw a copy of the health and safety review report for April 2017, which evaluated the monthly checklists undertaken across the site. These systems helped to keep people and staff safe.

We saw that the service had a health and safety subcommittee in place. We looked at the records of the health and safety meetings held with the director of operations on 7 December 2016, 20 February 2017 and 19 April 2017. We saw that the meetings discussed a wide range of health and safety issues including action taken from the previous meeting. They also reviewed accidents and incidents, health and safety champions updates, infection control updates, health surveillance of staff, building issues, staff training update, policies and procedure update, legislation and the British Safety Council external report. The report for the 19 April 2017 noted that the health and safety policy and procedures were in the process of being updated and should be ratified in June 2017. The registered provider confirmed this was the case.

We looked at what action had been taken by the service to help prevent the type of incident which prompted this inspection from happening again. The registered manager had sent a notification to all clinical staff to remind them to be vigilant and always ensure they were using the right sling in the correct position when transferring people. Slings were regularly checked on the unit concerned by the servicing contractor and condemned where necessary. The registered manager had met with all the teams to reinforce the need to use the amended moving and handling people forms and handover slings check to help keep people safe. The registered manager was looking at further improvements, such as stitching in the serial numbers on to the sling.

We saw that there was a policy and procedure in place for moving and handling people. A policy and procedure is an agreed way of working. We saw that this procedure needed to be updated so it was consistent with the dates refresher training was due, for example we noted certificates issued to staff stated

they were valid for 12 months so did the policy and procedure. In contrast, the staff team training recorded stated refresher training should be undertaken within 18 months. In addition, the role names allocated to people did not match those undertaking responsibility for health and safety. We were informed by the registered manager following our inspection that the training providers certificates had been amended to read 18 months. As stated in the Health and Safety Executive (HSE) guidance 'Getting to grips with hoisting people' employers need to make sure that staff receive adequate training and information on people moving and handling. This document states that there is no firm rule about how often training should be given.

We spent time talking with the nominated individual who was the chief executive officer (CEO) for the service about duty of candour. The aim of the duty of candour regulation 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 relation to care and treatment. It also sets out some specific requirements that providers must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology. Providers must promote a culture that encourages candour, openness and honesty at all levels. This should be an integral part of a culture of safety that supports organisational and personal learning. There should also be a commitment to being open and transparent at board level, or its equivalent such as a governing body.

We found that the provider had systems in place to support this and had where required followed them accordingly, commissioning independent advice and investigations to identify the root cause of incidents.