Heathcotes Care Limited

Heathcotes Chesterfield (Loundsley House)

Inspection report

Loundsley House
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Date of inspection visit:
16 August 2018
07 September 2018

Date of publication:
07 March 2019

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Loundsley House is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Loundsley House accommodates up to eight people in one building. On the day of our inspection there were 6 people living in the service.

We inspected the service on 16 August and 8 September 2018. The inspection visits were unannounced on both days. This was the first inspection of the service.

The service did not have a registered manager. 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. A manager was in post and plans to apply to the Care Quality Commission for registration.

People had not always been kept safe through the use of effective care planning and risk assessment and management. There was not always sufficient trained staff who were given clear directions on how to care for people with complex needs. The provider did not always have systems in place to recognise when they could no longer meet people's needs.

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Staff were not always deployed in the best interests of people and they worked very long hours without a break. Records did not always reflect what was happening in the service such as staffing levels and staff hours worked. They had not always been supported in a manner that enabled them to learn and flourish as staff members.

Care plans were basic and they did not always give staff clear directions on how to care for people who had complex needs. This impacted on risk assessments as up to date information on risk was not always available. Due to the lack of consistent management communications were not always effective. Staff said they had improved with the appointment of the new manager.

People's dignity was promoted and staff were caring in their interactions with people. However people's independence was not always promoted as there was not always enough staff to ensure they had an active social life at a time they wanted outside the service.

There was a complaints process in place. There was a quality assurance process in place. However it was not always effective and had not reflected the concerns raised during this inspection process. The new manager reviewed incidents and acted to reduce them.

The service was clean and fresh and there were processes in place to keep the service infection free.

Medicine was stored and administered as prescribed. People's consent to care was sought for daily personal care activities. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice. The provider was working in accordance with the Mental Capacity Act 2005 (MCA), and people had their rights respected in this regard.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

People had not always been protected from avoidable harm. Staff worked very long hours without a break. Staff were recruited appropriately. The service was clean and fresh.

Is the service effective?

Requires Improvement

The service was not always effective.

There was not always enough staff to ensure people's choices were effectively met. Some staff lacked experience to care for people with complex needs. People's health was promoted. People were supported to have a nutritious diet.

Is the service caring?

Good

People were cared for by kind compassionate staff. Independence was not fully promoted. People's dignity and privacy was promoted.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Due to staffing restrictions people access to the community was sometimes restricted. There was a complaints process in place. Staff were aware of people's needs although this was not always recorded in care planning.

Is the service well-led?

Requires Improvement

The service was not always well led.

The service lacked stable management although a new manager had been appointed. The provider did not have robust processes in place to review the service and to ensure improvements were carried out. Staff were not always supported.

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Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, to look at concerns we received about the service and to provide.

We inspected the service on 16 August and 8 September 2018. The inspection was unannounced and was conducted on 16 August by two inspectors and one expert by experience, and on the 8 September by one inspector. It was the first inspection of the service.

Prior to our inspection visit we reviewed information we held about the service. This included information received from local health and social care organisations and statutory notifications. A notification is information about important events which the provider is required to send us by law, these include allegations of abuse and serious injuries. We also contacted commissioners of the service and asked them for their views.

During our inspection visit we spoke with four people who lived at the service, five members of care staff and two representatives of the provider.

To help us assess how people's care needs were being met we reviewed all or part of three people's care records including their risk assessments. We also looked the medicines records of three people, three staff recruitment files, training records and a range of records relating to the running of the service, for example, audits and complaints. We carried out observations of care and support and looked at the interactions between staff and people who used the service. Because of the small size of the service we are unable to give examples of how care was delivered or to say what people told us as this could easily identify them and could compromise their right to privacy.

Requires Improvement

Is the service safe?

Our findings

This is the first inspection of the service. We found not all aspects of safety were consistent enough to protect people from avoidable harm. The service had a number of safety issues. These included incidents which could cause harm to others and staff . These had been reduced by actions taken the new manager and people and staff were now kept safe.

There were now systems in place to ensure people were kept safe. This included reviewing risk assessments and providing directions to staff on how to care for people. Because of this the number of incidents had reduced. Staff endeavoured to keep people safe. They were now proactive in recognising incidents that could escalate, for example people whose personalities clashed, and therefore could cause risk to people. The new manager had put strategies in place for staff to follow. These strategies included re-assessing people's needs and recognising and addressing when the service could no longer meet people's needs and keep them safe.

The provider's statement of purpose states, 'We have much higher staffing levels than usually found in a home for adults with learning disabilities. This is so we can give the people who use our service lots of support to do the things they like and to have a rich, fulfilling life'. However, we found staff worked long hours without a break or without the provider ensuring staff could deliver effective care while working such long hours. For example, they were rostered to work a 12 hour day followed by a 14 hour day and then a 12 hour day. No breaks were rostered in. We saw evidence that staff worked 16 hour shifts and on one occasion 24 hours without a dedicated break. The rotas did not represent the hours worked. We had to look at pay documentation to evidence hours staff worked. Staff told us they found these hours very difficult and left them stressed. We were unable to find evidence that the management of the service had been aware of these long hours or had taken care to ensure staff were fit to work long hours without an impact on the quality of the service they delivered. The new manager recognised this and was working to ensure staff rotas offered staff recognized breaks and staff were working within the European Working Time Directive.

A high number of staff did not have experience of caring for people with complex needs. They had received basic training and some of them told us they had struggled to cope with the complex needs of people. They said they now felt supported and the new manager offered direction on meeting people's needs and recognising when the service could no longer meet needs.

We did not speak to people about the medicines they took. Instead we looked at the medicines in the service and the records the service kept. Accurate records of this were made in the medication administration records (MAR's). Following the completion of the medicine round the staff member double checked the MARs to ensure they were properly completed. Medicines were stored appropriately and there were systems in place to ensure unused medicines were returned to the pharmacy.

Adequate steps had been taken to ensure people were protected from staff that may not be fit and safe to support them, as a safe recruitment process was in place. Each of the three staff files we viewed had the necessary information on the staff's identity, work history and security checks.

Loundsley House was clean and fresh and people using the service lived in a safe, clean, well maintained environment. There were processes in place to promote an infection free environment. People's bedrooms were personalised to reflect their own interests and preferences.

Requires Improvement

Is the service effective?

Our findings

Each person had a care plan and these reflected the basic needs and wishes of people. The service had not always been able to understand and meet people's more complex needs. This resulted in the past of at least one person receiving poor care because the provider did not always have systems in place to recognise when the service was no longer able to meet people's individual needs and because of this, action was not taken in a timely manner. This impacted on the person, putting them at risk of poor care and impacted on the emotional health of other people living at Loundsley House, as we were told they were often frightened and stayed in their rooms to avoid conflict. This had been addressed at the time of the inspection visit.

Staff had received training in caring for people that covered all aspects of care prior to starting work at Loundsley House. This included keeping themselves and people safe. Staff said that mostly they were able to put this training into practice. However there were incidents where they found it difficult to meet people's needs. The manager had addressing this and we were told Loundsley House was now a calm home for people to live in. On our visits we observed this to be true.

People had access to comfortable communal facilities, comprising of two large lounges and a dining area. Most bedrooms were personalised to reflect their own interests and preferences. This included people's bedrooms and we saw people had their personal possessions around them.

Staff we spoke with could not always ensure their care and support was delivered in line with legislation and nationally recognised evidence based guidance. They were aware of the need to promote people's rights under the Equality Act.

Staff told us they now felt supported. They said it had been difficult in the past, but the new manager was very supportive and was there for advice and guidance. The new manager had started to introduce staff supervision. Staff said they felt supported by the new manager and all agreed the support they got had made coming to work easier and more enjoyable. However there were no systems in place to ensure staff welfare following an incident at work where they could have been injured physically and there was no emotional support for staff.

People had their physical and mental health assessed and their needs met. People had access to their GP and when needed, staff referred people and if needed took them to the surgery visit. We saw the staff worked very closely with mental health care professionals. We saw staff followed the advice and guidance given by them and reported back if their advice was not effective. People had access to dentists and other associated health care professionals. People, where possible, were assisted to understand their condition and how it affected them and their lives.

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 the 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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards [DoLS]. We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

Most staff had a knowledge and understanding of MCA and DoLS. Information available showed that each person who used the service had had their capacity to make specific decisions assessed. Where people lacked mental capacity, appropriate applications had been made to the local authority for DoLS assessments to be considered for approval.

People were given food that supported their nutrition and their personal taste. We were told, "The food is good, I get what I like." At the time of the inspection visit no one had nutrition issues.

Good

Is the service caring?

Our findings

We observed people were treated with kindness and they were positive about the staff's caring attitude. We saw kind interactions between staff and people and we saw staff took time to ensure they understood what people wanted.

Staff communication skills were good and effective. Where people were unable to communicate their needs and choices, staff understood their way of communicating. Where people had a communication need, staff had learned from each other and were able to observe and respond to a person's body language. We saw staff ensure they made eye contact and used simple sign language to understand people's needs and wishes. People were given information in accessible formats.

People had their privacy and dignity promoted. Staff had received training about privacy and dignity; they knew how to protect people's privacy when providing personal care. We saw that staff knocked on people's doors before entering and addressed people in a kind and caring way. We saw staff throughout our inspection were sensitive to people's needs and were able to tell us people's moods and how their expressions showed their emotions.

Staff respected time people spent in their rooms and did not enter unless they had permission. Care was administered in a manner that promoted people dignity and privacy.

Staff knew about the things that people found upsetting or may trigger distress. However staff were not always able to control the environment and this caused distress to people.

People's families and representatives were welcomed to the service and were facilitated to assist people to make decisions that were important to them.

Advocacy information was available for people if they wished to speak with an independent person for advice on making a decision. Advocates also offer guidance and support for people who are unable to make decisions for themselves and may not have an appropriate family member or friend to speak on their behalf.

Requires Improvement

Is the service responsive?

Our findings

The service was not always responsive to people's needs. Because of this, care was not always person centred and staff deployment did not always suit the needs of people. The new manager was aware the care plans did not represent the needs and wishes of people. They had started the process of reviewing the care planning for all people.

People had been allocated additional time for activities in the community. These were not always planned around the person and were dependent on staff availability. For example, if someone needed two staff to keep them safe in the community, they were dependant on the senior or service manager being available to ensure this happened. This restricted activities and meant people could not have an active social life at times they chose particularly late evening and at night. The funding authority was aware of this.

We saw that people were asked about their personal goals, however there were not always care plans in place to ensure they had opportunities to pursue these. We did see where people had the opportunity to pursue employment they were supported to do this.

Staff knew people's likes, dislikes and preferences. They used this detail to care for people in the way they wanted. For example; details around how a person preferred to be supported with personal care was recorded and staff referenced this each day to care for the person.

Staff had good knowledge of people's needs. The service had not always captured this knowledge nor had they always recorded people's life stories. People assured us staff knew their preferences and used this knowledge to care for them in the way they liked.

Where possible, people were empowered to make choices and have as much control and independence as possible, including in developing care, support and treatment plans. Relatives were also involved where they chose to be and where people wanted that.

People received information in accessible formats and the registered manager knew about and was meeting the Accessible Information Standard. From August 2016 onwards, all organisations that provide adult social care are legally required to follow the Accessible Information Standard. The standard sets out a specific, consistent approach to identifying, recording, flagging, sharing and meeting the information and communication support needs of people who use services. The standard applies to people with a disability, impairment or sensory loss.

The complaints procedure was available in an 'easy read format'. The provider had a complaints procedure which they followed. All complaints were recorded along with the outcome of the investigation and action taken. We saw that staff had acted to investigate a complaint and had resolved the concern.

At the time of our inspection visit no one was approaching the end of their life.

Requires Improvement

Is the service well-led?

Our findings

This was the first inspection of this service. It was opened in June 2017. Prior to May 2018, there was no stable management in the service. Leadership and management did not consistently assure person-centred, high quality care and a fair and open culture. There was not consistent management in the service.

People whose needs could not be met were admitted to the service without an overview of the needs of people using the service been taken into account. This caused conflict between people in the service and resulted in staff receiving avoidable injury. There is a manager in post now who has addressed this issue and the service now met people's needs.

The service did not have a registered manager. 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. However since May 2018 the service has had stable management and the manager has applied to be the registered manager.

The manager had been in post since May 2018 and staff told us they have made a big difference to how the service was managed and meeting the needs of people. They showed a good knowledge of people and were aware of the issue we found. However, the quality assurance systems the provider had in place were not robust and had not identified the issues raised by us.

There were no systems in place to capture and act on staff feedback and the information they accumulated on caring for people. Staff told us that at times they did not feel listened to where they had told leaders the number of staff on shift was low and that this impacted on their ability to provide care in a timely way. Staffing levels were not always what was decided that was needed to provide good safe, effective and responsive care. The manager was aware of this and had started to put systems in place to address this.

The provider had no systems in place to review incidents and ensure lessons were learned and avoidable incidents were avoided. For example, staff were repeatedly injured and this was not reviewed in an open and honest manner. There was no support system in place for staff who were injured.

Care planning was under review as the manager was aware the care planning was not person centred and did not give staff sufficient direction in caring for people. However, while the care planning paperwork was not always up to date and accurate staff and the manager was confident they knew the people needs and wishes. Conversations with people supported this.

Staff now felt supported but in the recent past they felt unsupported and not listened to. They worked long hours without a dedicated break. When they were injured there was no system in place to support them. Staff rotas did not represent the hours staff worked. The manager was aware of this and had addressed this for the last month.

The new manager understood their duty of care to people and since they started the number of incidents had dropped and staff told us they are better able to care for people and to meet their needs and wishes.