Heathcotes Care Limited

Heathcotes Grove House

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service:
Heathcotes Grove House is a large detached house near the town centre. It is registered for the support of up to eight adults and children of 16 years and over with learning disabilities including autism. Five people were using the service at the time of our inspection. The service comprised eight bedrooms with en-suite facilities, two lounges, a conservatory, kitchen and dining room. To the rear was a patio area leading to a large lawn and garden with seating.

People's experience of using this service:
Systems in place had not always protected people from abuse. People had not been asked if they felt safe or what they could do if they worried or concerned.

Staff felt that sometimes people may feel unsafe while living at the service. Although staff told us they knew how to protect people from harm, some training in safeguarding had not been completed. When incidents happened sometimes these had not been dealt with appropriately to minimise people's risk. Some restrictive practices had been in use that were not in line with current legislation and national guidance. During our inspection the provider was making changes to make sure people were safe.

Risk assessments in place were detailed and person centred. However, some people's risk had not been identified or assessments were out of date. Medicines were not always managed safely. Medicine records were poor and this meant it was hard to tell what medicines people had received. During our inspection we found the provider had identified issues with people's medicine records and had started to make changes to put things right.

Staffing levels were safe but because of staff changes new staff and staff from other Heathcotes services were covering shifts. This meant people did not always have the continuity of care that they needed.

Staff did not always receive their induction training before they started to work at the service and some mandatory training had not been completed or had not been refreshed. This meant some staff may not have the skills and knowledge they needed to support people.

The staff we spoke with were knowledgeable about people's needs and told us about the risks they faced. They told us they wanted the best outcomes for people and were working hard to achieve these. Recent changes in management meant staff were receiving more support to do their jobs well and staff comments confirmed this.

Complaints had not always been recorded or responded to in a consistent way.

People were not always helped to communicate their needs or be involved in how the service was run. Although guidance had been given to staff about ways to communicate with people, this was not always

followed. Information was not always available to people in a format they could understand.

Following concerns raised, the provider had taken clear action to provide strong leadership at the service. This included a new management team and additional support for people and staff. They had made changes to the staff team and changed the way they checked the service was run so they could make things better for people. There was now an emphasis on creating an open and transparent culture. Although the changes being made were positive, these changes were new and we needed to be sure they have time to work properly. This is reflected in the rating we have given.

The provider was working with other authorities including the CQC to make sure improvements were made.

Rating at last inspection:
This was the first inspection for this service.

Why we inspected:
This inspection was brought forward due to information of risk or concern. Following an incident, we received information from the provider regarding concerns about the service. We completed this inspection based on these concerns. At the time of the inspection, we were aware of incidents being investigated by another agency.

Enforcement
The service met the characteristics of Inadequate in two key questions of safe and well led and Requires Improvement in effective, caring and responsive. Please see the action we have told the provider to take at the end of this report.

Follow up:
We will continue to monitor the service closely and discuss ongoing concerns with the local authority. The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

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?

Inadequate

The service was not safe.

Details are in our Safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective

Details are in our Effective findings below

Is the service caring?

Requires Improvement

The service was not always caring

Details are in our Caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive

Details are in our Responsive findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our Well-Led findings below.

Heathcotes Grove House

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.

The inspection was prompted by concerns raised by the provider and other agencies, about people's safety and governance at the service. We looked at these issues as part of our comprehensive inspection.

Inspection team:
Two inspectors attended the service on 10 and 14 May 2019.

Service and service type:
Heathcotes Grove House is a care home. People in care homes receive accommodation and nursing or personal care. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. However, they were not present at the time our inspection. The registered manager 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:
The first day of the inspection was unannounced. We told the provider we would be returning on the second day.

What we did:
Before the inspection we reviewed the information we held about the service. This included the statutory notifications sent to us by the registered manager about incidents and events that had occurred at the service. A notification is information about important events which the service is required to send to us by law. We also met with the local authority and their safeguarding team to gain their views.

During the inspection, we spoke with two people who used the service. Some people who used the service were not able to speak to us about their care experiences. When we were able to, we observed how the staff interacted with people in communal areas. We spoke with the managing director, the compliance manager (who was acting as the interim manager for the service), the quality assurance manager and three staff members. We looked at three people's care records, five staff files as well as a range of other records about people's care, staff training and how the service was managed. These included accident and incident records, medicine records, daily notes and quality assurance records.

After the inspection we spoke with two family members of people who used the service and the provider sent us some additional information such as the quality assurance audits, policies and ongoing improvement action plans.

Inadequate

Is the service safe?

Our findings

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

People were not safe and were at risk of avoidable harm. Some regulations were not met.

Systems and processes to safeguard people from the risk of abuse
• Systems and processes did not always protect people from possible abuse. People told us they felt safe and one person said, "Yes. I'm feeling OK." However, staff told us they thought some people may not feel safe because of the actions of other people using the service. One relative we spoke with told us they did not think their family member was safe and discussed their concerns with us. We also heard from one member of the public who had raised concerns about the service and how people were being supported.
• Although the provider had notified the CQC of several safeguarding incidents, we were concerned because these incidents did not result in the provider taking preventative measures in a timely way to protect people.

• People had not always been given information on what they should do if they did not feel safe and how they should report their concerns. We could not find any evidence that people had been asked how they felt living at the service.
• During our inspection we became aware that some restraint and restrictive practices had been in use that were not in line with current legislation and national guidance. The provider explained they had identified concerns in this area the week before and had been working with staff to ensure current legislation was followed. Staff confirmed they had received additional guidance and support in this area.
• All of the staff we spoke with during our inspection understood the signs of abuse and what to look for. However, following a recent incident some staff had appeared unclear on how to raise concerns or were wary of doing so.
• Staff did not always receive safeguarding training to ensure their skills and knowledge was up to date. Staff training for safeguarding should have been refreshed every year. However, training records confirmed six staff had last received safeguarding training during 2016 and 2017 and a further four staff members were overdue with their training. The provider confirmed safeguarding training had been arranged for staff at the end of May 2019.
• At the time of our inspection the provider was working with staff to reinforce their knowledge and competence in safeguarding and whistleblowing procedures.
• Although the provider was addressing these issues at the time of our inspection we remained concerned about the lack of transparency and openness within the service leading to the issues above not being identified and addressed immediately, consequently putting people at an increased risk of unsafe care.

The issues above were a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management
• At the time of our inspection the risk assessments in place were found to be detailed and thorough. The provider was in the process of producing person-centred, highly detailed risk management plans for people

whose behaviour challenged the service so that staff knew how to respond to specific challenging situations and avoid restraining people inappropriately. These took a proactive approach, focusing on making sure people's needs were met so they did not need to present behaviour that challenged. We saw one of these plans had been reviewed and completed between the two days we visited.
• Risk assessments in people's records were personalised to them. They were designed to allow people to take positive risks safely rather than restricting them from engaging in certain activities. Staff worked with people to help them understand risks and involved them in creating risk management plans, taking their preferences into account. For example, one person liked to keep their bedroom messy and staff supported them to understand and reduce the risks of fire, tripping and infection while keeping their room as they wanted it. Risk management plans were clear, detailed and showed how certain actions helped to reduce risks. We observed staff consistently following risk management plans when faced with behaviour that challenged.
• When people using the service were under 18 years of age, appropriate age specific risk assessments were in place, covering age related risks in the community and those risks associated with them using an adults' service.
• However, some risk assessments were not always up to date. One person's risk assessment had been created while they were staying at one of the provider's other services, before moving to this service. Although the format of the assessments would have been the same, their current risk assessments did not take into account the risks unique to where they were now living, such as their interaction with other people using the service.
• When people's needs were less challenging, some risk assessments were not always completed. One person used special equipment in the shower to help them stabilise but there was no risk assessment in place for this. The same person was at risk of seizures when they became anxious. The person told us, "loud noises and loud people" made them feel stressed, but there was no risk management plan around how they could safely live with other people at Grove House where the environment was often very noisy.
• The environment contained many features to ensure people's safety such as robust window restrictors, magnetic curtain rails and covered heated surfaces in all but one room. However, when we looked at the laundry room, the door was unlocked to the cupboard containing cleaning chemicals. The manager immediately locked the cupboard door and told us they would address the issue with staff as a priority because of the potential risk to people using the service.
• Health and safety and fire checks were routinely carried out at the premises, and people using the service were encouraged to be involved in these checks and be aware of safety issues around their home. Most people had personalised emergency evacuation plans so staff and emergency services had the information they needed in the event of a fire. However, two people using the service did not have these in place. Shortly after the inspection the provider sent us confirmation that these were now complete and in place.

Using medicines safely
• Medicines were not always managed safely. When we looked at people's medicine administration records (MARs) we found examples where records had not been fully completed. Records did not always show if people had received their medicines or the reasons why people did not take their medicines. For example, one MAR was not dated, only the person's initials were used to identify the records and it was not clear if that person had received their medicines or not because of inconsistent recording and days crossed out without further explanation.
• Staff had some guidance available to them when people required additional PRN or 'as required' medicine. This should include information such as how much medicine should be given, signs to look out for and when to offer the medicine. This includes verbal and non-verbal cues, the dosage and if there are any alternatives to PRN. When we looked at the guidance we found examples where information was poor or misleading and the guidance for one person's PRN was missing.
• Weekly medicine audits had identified the issues we found. However, we were concerned that staff were

altering records once issues had been identified. For example, audits identified a number of missing signatures in medicines records. However, when we looked at the corresponding records we saw staff had filled them in later, after the audit was completed. This meant we could not be sure how accurate medicines records were, or have assurance records were completed at the time of medicine administration in line with best practice guidance.
• We discussed our concerns with the provider who confirmed they had also identified these issues and were in the process of taking action to improve medicines management.

Learning lessons when things go wrong
• The service kept records of incidents involving people who used the service. The level of information provided was variable. One incident was fully recorded with details of the incident, action taken including any physical intervention and details of actions taken afterwards. This included reporting concerns to other authorities, debrief for staff and people using the service, sharing lessons and actions taken to reduce further risk.
• However, other examples recorded the use of physical restraint without a full debrief or details of action taken. Although the number of incidents was reported to senior management on a regular basis, the type of incident was not. So the provider was unaware of the nature of incidents and risk to people. After our inspection the provider contacted us to confirm they were now using a new approach that will allow them to monitor more effectively in the future.

The issues above were a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities)

Staffing and recruitment
• Staffing numbers were adequate to meet people's needs. The provider had made recent staffing changes and was using agency staff and experienced staff from the Heathcotes group to cover vacancies until recruitment of additional staff was complete.
• Although the staff we spoke with knew people and their support needs well, we were aware that new and agency staff may not have the knowledge they needed to provide the continuity of care required to support people.
• The provider had recently created a one-page "grab sheet" explaining all the important support information for each person, for new and agency staff to help them provide the care and support required.
• Agency staff were employed based on their experience and qualifications. However, some agency staff did not appear to have safeguarding children as part of their training. The provider told us they would investigate this as a matter of urgency.
• Systems were in place to make sure staff were recruited safely. However, sometimes these were not checked to make sure records were complete. When we looked at staff recruitment files, some paperwork was missing, incomplete or had not been dated. For example, one staff member's induction record had not been dated and gaps in the employment of another staff member had not been identified. Checks such as this help make sure staff are safe to work at the service. They are also a requirement under the regulations.
• Criminal record checks had been completed and additional checks had been carried out for staff when they were working with children.

Preventing and controlling infection
• Staff had access to personal protective equipment when needed and all staff had received training in infection control and food hygiene during their induction. Cleaning schedules were in place as part of the daily shift planner. A yearly infection control audit had last been completed in September 2018, but we did not see any other regular checks in place.
• The communal areas of the service were clean and tidy. Communal bathrooms and toilets had hand

washing and drying facilities and were clean and free from unpleasant smells.

Requires Improvement

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

The effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent. Regulations may or may not have been met.

Staff support: induction, training, skills and experience
• Staff in place at the time our inspection told us they received enough training to provide people with the care and support they needed. Staff thought the training Heathcotes provided was good and focused on the needs of people living at the service.
• We looked at staff training records since the service had started to provide care for people in January 2019. We found inconsistences in staff training. For example, records indicated that some staff completed their induction training many weeks or months after their start date. This meant staff were supporting people without the basic induction training.
• We were also concerned that staff had not completed some specific training relevant to their roles. For example, records indicated from January to April 2019 only three staff had received training in safe handling of medication. We spoke with the provider about our concerns. They told us that following very recent staff changes additional staff with medicine training were now working at the service. This meant trained staff were always available to give people their medicines.
• Some people using the service had complex needs and required behaviour support plans. Mandatory training for staff included specialised training in behaviour support to help staff manage behaviour that challenged proactively while minimising the use of restrictive physical interventions. However, records indicated at least three staff had not received this training and a further five staff had not completed their yearly refresher. This meant staff may not have the skills they needed to support people in the least restrictive way while keeping themselves and others safe.

These issues amounted to a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to eat and drink enough to maintain a balanced diet
• People enjoyed a variety of healthy food. One person told us, "I like the food." People we spoke with listed foods they enjoyed and told us they were able to have those meals at the service.
• The service did not always support people to sufficiently to manage the risks associated with diet and nutrition. Staff kept records of people's weight as part of monitoring their health. The records showed some people using the service were not at a healthy weight. Although for some people this was because of other conditions which were managed appropriately, others had not received support to seek medical advice around achieving and maintaining a healthy weight. People did not always have opportunities to engage in exercise. One person's care plan stated they had said they did not like exercise, but the service had not looked at ways of engaging the person in physical activity they might enjoy.
• One person had been told by a doctor they sometimes did not eat enough during the day, which increased

their risk of having seizures. It was important for staff to monitor the amount of food the person was eating to make sure this risk was reduced. However, when we looked at records over a period of 13 days, only six days were completed and a further four days showed incomplete records. None of the records confirmed the quantity of food the person ate. Poor record keeping meant we could not be sure if this person was supported to eat enough to manage their risk of having a seizure.

Failure to identify risk and keep accurate records in relation to people's diet and nutrition is a breach of breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
• Each person had an assessment of their needs. People and their families were involved in this process, as were the services people had previously used and others who worked with them such as social workers. The provider used a standard assessment tool to assess whether the service could meet their needs, how challenging those needs might be for the service and whether the service was able to manage risks.
• However, we were concerned that the assessment process did not consider the support needs of other people living at the service and how the impact of some people's behaviour may affect them. We discussed our concerns with the provider who was unable to answer our questions but assured us they were undertaking a full review of the assessment process to understand why people's varied complex needs had not been considered when planning people's care.
• Although we had identified people had not always received care in line with national guidance and standards regarding the use of restraint, the interim manager, in post at the time of our inspection, was qualified to train staff in a behaviour management technique that avoided the use of restraint. This meant they were familiar with the appropriate standards, guidance and the law. They explained to us in detail the needs of the people using the service and the work they had started to assess the support people needed to manage behaviour that challenged the service.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
• People told us they had access to healthcare services when they needed them. One person told us, "I get to see the doctor when I need to." Another person received support to visit the doctor's surgery during our inspection. People visited healthcare providers for regular check-ups or when they needed to. People who had recently moved into the service had not yet attended all their check-ups, but staff had arranged appointments for them.
• People's care plans and health action plans contained details of other services they used such as specialist clinics. This meant staff could seek advice from them or support people to use them when necessary.
• People's assessments included records of any medical conditions or disorders people were diagnosed with and the services they used to help them manage their health conditions.
• Care plans gave staff information to help promote people's mental health and signs to look for when people became ill. People had detailed health action plans covering all aspects of their health such as diet and nutrition, men's or women's health and skin care. There was information on how staff should support people to stay healthy and manage their health conditions.

Adapting service, design, decoration to meet people's needs
• The service had been adapted to meet the needs of people living there. There was a main lounge, a smaller quiet lounge, a kitchen, dining room and conservatory, so private space was available for those people who wanted this. There was a large garden accessible via stairs and a ramp. At the time of our inspection no one at the service was a wheelchair user and people were able to access all areas of the house and garden.

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.

• There were records showing the provider followed guidance and complied with legal requirements when making decisions on behalf of people without capacity. This included involving families and other professionals involved in people's care to make sure decisions were made in a person's best interests.
• DoLS authorisations were up to date and conditions were met. For one person, a further assessment was planned to decide whether additional restrictions on their liberty were needed to keep the person safe.
• When decisions needed to be made about people's care and treatment, the provider used appropriate tools to assess whether people had the capacity to make a decision or to give consent. This included age-appropriate procedures for people under the age of 18. However, one person's records indicated two decisions had been made about their care but there was no evidence of this process being followed for those decisions. Another person's care plan stated a relative had a Lasting Power of Attorney, which legally enables one person to make decisions on behalf of another, but there was no documentary evidence of this. We raised our concerns with the provider who agreed to review the person's care records.

Requires Improvement

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 did not always feel well-supported, cared for or treated with dignity and respect. Regulations may or may not have been met.

Ensuring people are well treated and supported; respecting equality and diversity
• People told us they liked the staff who were on duty when we inspected. One person told us, "The staff are all right." Another person said, "I have no problem with any of the staff who work here now. They're all good here. They help me feel relaxed and calm." One relative told us, "I have no issues with the current staff at the service." Another relative said, "Two of the staff have been brilliant" but went on to explain more continuity was needed to make sure their family member was safe.
• The staffing structure had recently changed and new staff had been introduced to the service. This meant the provider faced a challenge in creating a stable, consistent team of staff who knew people well. However, we saw some good examples where experienced staff had been brought in from other Heathcotes services to support those remaining staff and offer continuity of care and support for people. For example, the service worked hard to keep the same two staff members with one person to help them feel safe and well supported. We observed a meeting between staff concerning one person who used the service. Staff discussed the person's needs and preferences to help make sure they received care and support from staff who knew them well.
• Care plans contained detailed information about people to help staff understand them and get to know them well. This included information about people's cultural backgrounds, sense of humour, what made them happy and what made them unhappy. Each person had a brief pen picture so new or temporary staff could get to know key information about them quickly.
• Staff were not always able to offer the support people needed, when they needed it. One person told us they did not like the noise in the service as it made them feel anxious. They explained staff had supported them to enrol on a course to learn relaxation techniques to help them when it was noisy, but felt they needed staff support during these times. During our inspection there were several periods where other people were shouting and staff prompted the person to move to a quieter part of the home if they wanted to. However, the person told us they could still hear the shouting and it worried them. We were concerned because during these times staff did not offer emotional support to help the person manage their anxiety.
• For people who had behaviour management plans, these included information about the emotional support people might need after incidents, such as reassurance and support to calm down.

Supporting people to express their views and be involved in making decisions about their care
• Staff knew about people's individual communication styles. Information about people's level of understanding and the signs, gestures and phrases they used to indicate how they were feeling or what they needed was in care plans so staff could share this information reliably.
• People's care plans contained information about how to involve them in the running of the home, for instance how to help them choose what household chores to participate in, and how to make sure they

understood their care plans and were as involved as possible in planning their care.
• We observed staff talking to one person after they were involved in an incident. Staff spoke to the person in a kind, patient and respectful tone, supporting them to manage their emotions while making sure they understood the information they were giving them about their responsibilities and how to stay safe. Although this was a good example of how staff engaged with one person to make sure they understood what had happened, we could not see how other people using the service were able to express their views, or be involved in decisions about their care. We did not observe any of the communication methods described in people's care plans in use and spoke of our concerns to the interim manager. We were assured that people would be supported to express their views and were told about plans to introduce various methods of communication to help those people who were not verbal to communicate.

Respecting and promoting people's privacy, dignity and independence
• Care plans showed staff considered how to support people to maintain and increase their independence. There was information about what people were able to do for themselves, what they needed help with and what they would like to learn how to do without support.
• Some people had complex needs and we observed staff were always on hand to support people. Staff provided reassurance when people needed it, they knew people's routines well and made sure they followed these. Staff gave us examples of how they respected people's privacy and dignity.
•When people wanted some privacy in their own rooms we observed staff stayed nearby so they could quickly respond if the person became anxious or upset.

Requires Improvement

Is the service responsive?

Our findings

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

People's needs were not always met. Regulations may or may not have been met.

Improving care quality in response to complaints or concerns
• People told us they felt confident to tell staff about any problems or concerns. One person said, "[Acting manager] sorts out any problems and tells me what I should do if I have a problem." Although for those people who were non-verbal or had additional communication needs it was hard to see how they were able to give feedback, including raising concerns.
• A complaint policy was in place with a clear outline of the procedure and time scales involved. However, we did not see any information for people in a format they could easily understand. We were concerned that some people may not have been given the opportunity to express their views about their care and support at the service.
• Records indicated that one complaint had been made since the service started providing care to people. We were aware of other complaints that had been made more recently but records had not been made. Although we were assured the provider was addressing the most recent complaint and had provided feedback to us, we were concerned the recording of complaints had been inconsistent and as a result may not have been investigated in a timely way.

These issues amounted to a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Planning personalised care to meet people's needs, preferences, interests and give them choice and control
• Although people's needs were assessed when they first started to use the service, supporting care records were not always completed to so it was hard to see how the provider could make sure people's needs were being met. For example, daily notes were not always completed and sometimes poorly completed or inappropriate language was used. Food intake records were not always dated or completed. There were gaps in personal care records. For example, during April there were 15 days where one person's personal care record was not completed. Night time checks were not always complete or were completed inappropriately, so it was hard to see if people received the care and support they needed to meet their needs.
• People had opportunities to go on day trips. On the day we visited two people went to a zoo with staff and people told us about a recent trip to the seaside. One person told us they were looking forward to a holiday they had planned for later in the summer. One relative told us their family member was engaging in activities much more since they had been living at Heathcotes Grove House and there was far more for them to do there, compared with their last home. Another relative was more concerned and told us their family member's activities appeared to have reduced and lacked the structure they needed to become fully engaged.
• There was information in care plans about the activities people enjoyed. However, records did not always show they were offered these activities. For example, one person liked sensory-based activities, but none

were recorded in their activities log for the month leading up to our inspection. For another person, over six weeks' worth of records there were no activities recorded other than walks and seeing a relative. The manager explained this person spontaneously chose activities while out on their walks, but because these were not recorded we did not see evidence that the person had enough meaningful activity to occupy their time.

• One person who used the service was under 18 years old but they were not enrolled in any educational courses. The manager told us this was because the person was very unsettled at the moment and would be unlikely to engage safely with any classes until their home routine was more stable.

• Care plans included records of people's goals and how staff supported them to work towards them. People had personal development plans so they could work a step at a time towards their goals. However, at the time of our inspection there was little evidence available to see how staff had engaged with and encouraged people in this way.

• People's care plans took into account their needs, risks and how they preferred to do things. This included people's preferred personal care routines, where they liked to eat, the home environment and how they liked to spend their time. One person needed a very structured routine and the service had helped them create a timetable.

End of life care and support

• At the time of our inspection no one at the service was receiving end of life care. However, staff had started conversations with some people about end of life and what they would like to happen. These conversations also extended to provide support for people when their relatives were unwell. Staff spoke of their plan to engage one person in discussions about what would happen if that relative died or became unable to help them, so the person would have a better understanding of what was happening when the time came.

Inadequate

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

There were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care. Some regulations were not met.

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

• The service had a registered manager. However, they were not available to speak with us during our 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.

• Following recent safeguarding allegations, the managing director of Heathcotes South had taken operational charge of the service and had appointed an interim manager to oversee the day to day running of the service while changes were being made. During our inspection there were high levels of engagement with staff, together with management support and direction. However, it was openly recognised there had been failings at the service and managers were keen to identify and understand the reasons why.

• Although the provider had systems in place to review the quality of the service, including regular quality assurance audits by the provider, the area manager and the registered manager, they had initially failed to identify issues that may have impacted on people's safety. The provider explained they had recently changed the way they conducted their quality audits and the most recent audit undertaken a few weeks before our inspection had highlighted many of the issues we found. The provider had started to address issues and had a detailed action plan in place to make service improvements a priority.

• Other audits and safety checks were carried out. For example, weekly and monthly checks such as audits of medicines management, care records, fire safety and checks of fridge, freezer and water temperatures. However, throughout our inspection we found issues with the quality of records within the service that may have impacted on the quality of care people received.

• Some people's care records were not accurate. Although medicine audits had recently been carried out, errors identified were altered after the event. Previous medicine records were poor and we were unable to find evidence that audits had been carried out at that time. Day and night time records for people's care were poor or incomplete, and some care planning documentation had passed the date it was due for review.

• People's risk had not always been identified and recorded. Some risk assessments were not dated so we could not confirm they were up to date with people's needs and preferences. When people experienced epileptic seizures, it was hard to see how the provider monitored these to identify increased frequency or patterns and look to reduce risk. Personal care checklists were not always completed, meaning there was not always evidence that people had received the support they needed with personal care.

• Systems did not allow the provider to monitor staff training. Staff training was incomplete and staff were working without having received a full induction to the service.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

• People knew who the interim manager was. One person told us, "[The manager] is all right." Another person said, "I think [interim manager] is very good. He helps keep things under control." They also told us the interim manager had given a telephone number to their family member to call if they were worried about anything. Relatives told us they had recently been introduced and had discussions with the interim manager about their family members' care. One relative told us they had confidence in the interim manager and the managing director and the work they were currently undertaking, but felt there had been "fundamental flaws in the way the service was operating and managed," and these would not be addressed until a permanent, experienced manager was in place.

• Some people's needs had been overlooked and equality characteristics ignored because staff were mainly concerned with managing the behaviour of those people with higher needs. The mix of people using the service had not always been considered, with some people being placed together inappropriately in a way that compromised their safety and wellbeing. This had a negative effect on the culture of the service and impacted on the way staff engaged with people.

• People were not always involved in the running service. We were unable to evidence how people were able to raise concerns or if they did, what action was taken. One person told us, "They don't ask me [about my opinions of the service and how to improve it] but they can do if they want. I'd like that."

Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on their duty of candour responsibility; Continuous learning and improving care

• Although incidents were reported it was hard to see how the provider had used this information to make improvements to the care people received. We spoke with the managing director about the process in place and why they failed to identify issues. They had identified the changes they would make to allow them to identify and address potential concerns.

• Recent events had identified more work was required to improve the culture of the service and making sure staff were confident reporting concerns and speaking up. Staff told us there had been an emphasis on openness and transparency and could see things were improving. Comments included, "I can see it getting better, even over the last few weeks" and "I can clearly see what [the manager] wants to achieve, he is very clear. I can see the changes already."

• Senior managers told us about lessons they had learned from recent events and the actions they were taking to ensure the same things did not happen again. They were carrying out a 'root and branch' analysis to identify what had gone wrong.

Although the provider had started to make improvements, the issues identified above amounted to a breach of regulation 17 of the HSCA 2008 (Regulated Activities) Regulations 2014.

Working in partnership with others

• During our inspection staff and managers worked with us and other agencies that were visiting or contacting the service. They were cooperative and keen to make changes to improve the service.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider did not do all that was reasonably practicable to mitigate risk. Medicines were not always managed safely. Regulation 12 (1), (2)(a)(b)(g).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The systems in place did not always keep people safe. Staff did not always understand their responsibilities . Restrictive practices were not always used in line with current national guidance. Regulation 13(1), (2), (3), (4)(b).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints People were not given the information they needed to make a complaint. The provider did not record and act on complaints without delay. Regulation 16(1), (2).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not always assess, monitor

	and improve the safety of the service. The provider did not always identify risk to people and did not introduce measures to reduce or remove risk. The provider failed to keep accurate and up to date records. Regulation 17(1),(2)(a)(b)(c).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff did not receive the appropriate training and support to carry out the duties they were employed to perform. Regulation 18 (2)(a)