Heathcotes Care Limited

Heathcotes Preston

Inspection report

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Preston
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Website: www.heathcotes.net

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Heathcotes Preston is a specialist care home for adults with a learning disability, mental illness and who may have challenging behaviours and associated complex needs. The service can support up to seven people. At the time of the inspection four people resided at the service.

All bedrooms had ensuite facilities. People had access to shared communal areas and a kitchen.

People's experience of using this service
The provider failed to consistently ensure people were protected from avoidable and intentional harm. People were not always effectively risk assessed before admission and this led to placement breakdown.

The provider did not always consider mental health recovery or ensure staff had received necessary training to support people with complex needs.

Staff recruitment was not always safe. New staff were deployed to support people with unpredictable and complex needs before they had undertaken induction training. This placed people at risk of avoidable harm.

The culture at the service required improvement. We observed staff on one-to-one support with people standing over them and they did not always engage with the person despite being in their personal space.

People told us they had built trusting relationships with staff and enjoyed accessing the community with their support. We observed some positive interventions between service users and staff. However, due to the environment being chaotic staff were unable to maintain a consistent approach with people they supported.

People were not consistently supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible; the policies and systems in the service did not support this practice.

The principles and values of Registering the Right Support other best practice guidance ensure people with a learning disability and or autism who use a service can live as full a life as possible and achieve the best outcomes that include control, choice and independence. At this inspection the provider had not always or consistently applied them.

The outcomes for people did not fully reflect the principles and values of Registering the Right Support for the following reasons; lack of choice and control, an unsettled environment and reduced inclusion because of the heightened needs of one person who had been admitted to the service without a sufficient assessment to check that their needs could be met.

There were deliberately no identifying signs, intercom, cameras, industrial bins or anything else outside to indicate it was a care home. Staff were also discouraged from wearing anything that suggested they were care staff when coming and going with people.

The size of service meets current best practice guidance. This promotes people living in a small domestic style property to enable them to have the opportunity of living a full life. However, due to the complexity of people who resided at the service and limited communal space the provider would need to consider compatibility of prospective service users before they were admitted.

Quality assurance systems were not robust and had not identified the failings found at the inspection. The manager did not always act on their duty of candour responsibilities and safeguarding incidents were not always reported in a timely way.

People were not always safeguarded from abuse and improper treatment.

People were encouraged to maintain an independent lifestyle and undertake shopping and cleaning tasks. Staff promoted people's dignity and respected their culture.

People had access to easy read information including the complaints procedure and statement of purpose. People told us they felt confident to raise their concerns.

Staff received regular supervision with their line manager.

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

Rating at last inspection
This was the first inspection at Heathcotes Preston. The service was registered May 2018.

Why we inspected
This was a planned inspection.

Enforcement
We have identified breaches in relation to; failing to protect people from avoidable harm, failing to effectively risk assess, failing to embed robust governance systems, failing to consistently safeguard people, failing to provide person-centred care and failing to ensure competent and trained staff were deployed at this inspection.

Please see the action we have told the provider to take at the end of this report.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
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.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of

preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

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?

Inadequate

The service was not 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?

Inadequate

The service was not 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 Preston

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. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
The inspection team consisted of three adult social care inspectors.

Service and service type
Heathcotes Preston is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. 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. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. The registered manager was not based at the service and had not been consistently involved, they were not present at the inspection due to personal commitments.

When the service was registered a manager was appointed however, the manager was not registered. At the time of the inspection the manager told us they had started the application process to become the registered manager.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
Prior to our inspection we looked at all of the information we held about the service. This included any safeguarding investigations, incidents and feedback about the service provided. We looked at any statutory notifications that the provider is required to send to us by law. We used a planning tool to collate all this

evidence and information prior to visiting the service.

We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections.

During the inspection we spoke with everyone who lived at the service. We spoke with the manager, the area manager, two team leaders and four support workers. We looked at a variety of records which included the care files for four people who used the service, incident and accident records and three staff recruitment files. We also reviewed a number of records related to the operation and monitoring of the service, staff training and medicines management.

After the inspection we continued to seek clarification from the provider to corroborate evidence found. We looked at training data and quality assurance records. We spoke with three external health care professionals responsible for the social care placement for one person who lived at the service. We communicated with the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

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.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong
- People were not always protected from the risk of avoidable and intentional harm.
- People were placed at significant risk of harm because the service failed to carryout comprehensive assessments before admission, on admission and as people's needs changed. For example, we found people were admitted to the service without proper assessment and this led to placement breakdown and also placed them at risk of avoidable harm because the provider was not able to meet their complex mental health needs.
- The provider failed to ensure lessons were learnt and effective action was taken to understand the behaviours of people in the service and consequently the risk this posed to themselves, other service users and staff. Systems in place to record lessons learnt were not used.
- There was a distinct lack of expertise and competency throughout the staff team which meant people with complex mental health needs and learning disabilities did not always receive safe and effective support.

Failure to adequately assess, monitor and mitigated risk placed people at significant risk of avoidable harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- People's care records showed consideration for positive risk taking. Before and during the inspection a complex situation with a service user took precedence and we found this negatively affected the support others received. People told us staff had interacted with them in a positive way when they felt unable to manage their behaviours for example; self-injury. Care records showed effective risk management and reduced instances in relation to self-injurious behaviours for one of the service users and this was for a sustained period of time.

Systems and processes to safeguard people from the risk of abuse
- People were not always protected from the risk of abuse. Safeguarding incidents were not always referred to the local authority. For example, one person placed another at risk of harm due to sexualised behaviours. The provider failed to take necessary steps to safeguard both people. On the second day of the inspection we were informed staff evacuated three people into the garden because of the risk another person who lived at the service posed to them. The incident was not escalated to the management team and a safeguarding alert was not made at the time of the incident.
- We observed new, untrained staff supporting people when they were distressed and agitated. This meant people were at increased risk because staff supporting them were not trained in de-escalation techniques or mental health awareness.
- People were not consistently supported in the least restrictive way possible. We observed staff supported one person in a restrictive way without consideration for other positive interventions to deal with their

behaviours. We felt the individual was being supported in a negative way because they were not subject to a lawful order such as, a Deprivation of Liberty Safeguards (DoLS). We asked the manager to make a safeguarding alert to the local authority in relation to this individual.

The lack of robust systems and processes to safeguard people demonstrated the provider was in breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

● Staff were not always recruited safely. Previous employment checks for staff's background and character were not robust, which meant the provider did not always carry out sufficient checks on staff's aptitude for the role.

The lack of robust recruitment systems demonstrated the provider was in breach of Regulation 19 (Fit and proper persons employed) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider increased staffing levels at night time during the inspection because of the unpredictable behaviours a person presented with. Staff told us they felt the service was adequately staffed.
● People were provided with one-to-one support in the service and two-to-one support in the community. The level of support was determined by the provider and commissioning authorities.

Using medicines safely

● Staff followed safe systems for the storage and administration of medicines. The medicines room was clean and organised. People's medicine records held clear instructions and included personalised information about their preferences.
● The provider encouraged people to maintain their independence around medicines management. Staff carried out self-administration risk assessments to support people to manage their medicines in a safe way.
● Staff demonstrated good understanding about people's medicines and in particular about rescue medicines. Protocols for 'as and when required' medicines were not completed. We discussed this with the manager and they assured us protocols would be implemented.

Preventing and controlling infection

● The provider had an infection control policy and procedure with best practice information. Staff had access to protective clothing and cleaning schedules were followed.
● The house was clean and people were encouraged to maintain cleaning skills as part of their daily living routine.

Inadequate

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.

There were widespread and significant shortfalls in people's care, support and outcomes.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- People's physical, mental and social needs were not always holistically assessed in a timely way. People lived with complex needs and this placed them at risk of continued placement breakdown.
- The provider failed to consistently ensure people were supported to achieve their goals and aspirations. Goal setting for people with enduring mental illness and learning disabilities is often an essential technique to help them feel positive and in control of their lives.
- The manager told us the service did not work in line with a mental health recovery model.

People were not consistently supported in a person-centred way. The provider was in breach of Regulation 9 (Person-centred care) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience

- The provider failed to deploy sufficient numbers of staff with the competence, training and experience to support people with complex mental health and learning disability needs. This placed people and staff at risk of significant harm.
- Staff were deployed to support people with complex and unpredictable needs before they had received induction training. We observed a new, untrained support worker use unsafe and restrictive practices with a person who presented with challenging behaviours. This placed the individual and the staff member at significant risk of harm.
- The provider's statement of purpose included information about what type of people the service could support; people with mental illness, including personality disorder, autism and Asperger's syndrome. The provider's training matrix showed some staff had received training in mental health and autism awareness. However, from our observations and discussions with staff, it was clear they had not received enough training to make sure they could support people with such complex needs.
- People were accepted to the service under conditions of the Mental Health Act (MHA). Staff had not been trained in understanding their responsibilities when supporting people under conditions of the MHA.

The lack of robust systems and processes around staff training and induction demonstrated a breach of Regulation 18 (Staffing) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Staff told us they felt supported by the team leaders and manager. Staff had supervision with their line manager on a regular basis.
- Staff told us they did not always feel the on-call manager was able to support them because they did not understand the complexity of people they supported.

Ensuring consent to care and treatment in line with law and guidance

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.

● Staff followed a system to assess people's mental capacity prior to requesting their consent or making decisions on their behalf. MCA assessments had been completed with a good standard of information for most people. However, we found the provider failed to consider lawful practices for one person, who had been admitted to the service without any formal agreement to carry out restrictive practices such as restraint and living in a secure environment.

The provider failed to consistently protect people from improper treatment and therefore was in breach of regulation 13 (Safeguarding service users from abuse and improper treatment) 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 were encouraged to maintain their independence around meal preparation and shopping. We observed people accessed the communal kitchen and staff supported them when required.
● Staff assessed people's nutritional needs and monitored their weight if this was an identified need. It was routine practice for staff to monitor and record all service user's diet intake. This was not person-centred practice.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● People were often admitted to the service from out of area. For example, two people came to the service following acute mental health inpatient treatment. Both individuals were placed away from immediate family and discharged to the service without a comprehensive plan should they need crisis mental health support. The provider failed to effectively work with other agencies to develop a risk assessment and support plan before they were transferred to the service and this led to placement breakdown and crisis incidents.
● People had access to health care professionals such as the GP, social workers and care co-ordinators. People told us they were supported to attend appointments.

Adapting service, design, decoration to meet people's needs
● The service can accommodate up to seven people. During the inspection we found the house was chaotic because of the number of staff required to support people. Should the service facilitate seven people it is likely to impose on people's personal space and could cause heightened behaviours. All of the people who resided at the service at the time of the inspection lived with autism and this meant they could be sensitive to noise and disruption, further increase in the numbers of people within the house should be carefully considered in line with registering the right support guidance for providers.

● During the inspection we observed a service user damage their bedroom environment due to increased behaviours. The environment had not been adapted to facilitate emergency water cut-off and this meant the situation was difficult for staff to manage and allowed the individual to continue damaging the environment. Incident reports showed how an individual attempted to use the first-floor balcony as an act of self-injury. The open balcony did not protect people from the risk of jumping from a height.
● Other aspects of environment design to accommodate people with unpredictable behaviours had been considered. For example, anti-ligature curtain poles and secure doors. During the inspection maintenance work was carried out to facilitate locking the kitchen.

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.

Ensuring people are well treated and supported; respecting equality and diversity; Respecting and promoting people's privacy, dignity and independence

- People were not consistently treated with respect. We observed staff reacted in a negative and provoking manner towards a service user when they became distressed. Staff lacked understanding of how to support people with complex mental health needs and across both days of the inspection we observed staff stand over people on one-to-one support and not engage with them in a person-centred way.

The lack of staff competence which led to poor interventions with people who lived at the service meant the provider was in breach of regulation 10 (Dignity and respect) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- People were supported to maintain their individuality and treated with equality. We observed staff listen to people's expressed wishes and supported them to carry out daily activities which were important to them.
- People told us, "Yes the staff are nice" and "Everyone is kind to me." We saw people had built trusting relationships with staff and were keen to spend time with them outside of the service. People were supported to access the community and staff encouraged them to maintain their dignity.

Supporting people to express their views and be involved in making decisions about their care

- People were encouraged to attend monthly house meetings and minutes were recorded. People told us they felt involved in making decisions about their care and some care records showed people's involvement in the care planning process.
- We observed people approached staff to inform them if they were not happy with a situation and seek out staff support when needed.
- The service did not consistently evidence how people were involved in review of their support plans. However, we found people who lived at the service were verbally updated about things that were important to them. For example, one person had appealed against a decision made about their care and support and when they asked, the manager updated them.

Inadequate

Is the service responsive?

Our findings

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

Services were not planned or delivered in ways that met people's needs.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- The provider failed to carry out comprehensive assessments for people before they were admitted to check if they would be compatible to live with others at the service. This placed people at significant risk of avoidable harm and abuse. After the inspection the provider submitted evidence of improved procedures for the admission of people to the service and this included a compatibility assessment.
- Information about people's back grounds and known risks before admission were not always immediately risk assessed and care planned. This meant the provider could not be sure staff had the information available to provide person-centred care.
- Specific incidents and significant events were not clearly recorded in people's care records. This meant staff did not always have access to important information to be able to support people in a person-centred way.
- The provider did not always make sure they could support a person before they were admitted or transferred back to the service.
- At the time of the inspection three people who lived at the service told us they felt unsafe because of the behaviours of another service user, people had changed their usual routines and felt distracted by the chaotic atmosphere. People told us staff had supported them as much as possible.

The failure to consistently provide person-centred care meant the provider was in breach of regulation 9 (Person-centred care) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- People had access to easy read material including the complaints procedure and statement of purpose.
- People were supported to follow their interests and take part in activities that were socially and culturally relevant and appropriate to them. We observed people access the local community with support from staff. People told us about activities they enjoyed participating in. People's activities were individualised.

Improving care quality in response to complaints or concerns

- People told us they felt confident to raise their concerns and make a complaint. People had access to easy read complaint information. The manager told us there had not been any complaints.
- We observed people approached the manager and asked to speak with them in the office. We could see people had built a trusting relationship with the manager and team leaders.

End of life care and support

- Staff had not received training in end of life care or bereavement awareness.
- The service had considered ways to support people with end of life care. We looked at people's care records which evidenced end of life preferences. However, we found that one person had experienced the

death of a family member and their care plans did not show how they were supported with bereavement.
● There was an end of life policy and procedure to guide staff when supporting people to make decisions in a person-centred way.

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.

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

- The registered manager was not based at the service and had not been involved in quality assurance processes. The manager had been in position since the service was registered May 2018 however, they had not started the application process to become a registered manager until April 2019.
- Shortfalls found at this inspection had not been identified by the provider's quality assurance systems. After the inspection the provider submitted evidence of improved quality assurance systems which included audits and incident analysis.
- Accidents and incidents were not always communicated to senior management. We found staff had not consistently been guided during specific incidents because staff had not always escalated their findings or concerns. After incidents were reported the manager failed to carry out a comprehensive investigation or consider route cause analysis.
- Safeguarding incidents were not always reported in a timely way.

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

- The manager was not fully aware of their role and responsibilities, in line with regulatory requirements. The manager was supported by an area manager. However, shortfalls had not been identified prior to the inspection.
- The manager had not effectively identified and managed risk therefore, people were placed at significant risk of avoidable harm.

Failure to embed robust quality assurance systems demonstrated a breach of Regulation 17 (Good governance) of The Health and Social Care Act 2008 (Regulated Activities)
Regulations 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

- The manager did not consistently promote stakeholder involvement. Stakeholder surveys were issued in May 2019 however, at the time of the inspection results had not been collated or analysed. Staff meetings were not carried out or recorded.
- The service had not engaged with any external social care initiatives or forums. External professionals were involved with people on an individual basis. Staff had not been appointed as champion

representatives for local authority steering groups. This type of partnership working improves best practice and access to local resources including training.

● Staff told us the manager was approachable and listened to their concerns and ideas. We observed the manager and regional manager support the staff team throughout the inspection.

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 9 HSCA RA Regulations 2014 Person-centred care The provider failed to ensure people were supported in a person-centred way. Regulation 9 (1) (2) (3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider failed to consistently ensure people were treated in a respectful way. Regulation 10 (1) (2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider failed to consistently ensure new staff were checked for character and employment history before they were appointed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed to deploy sufficient numbers of suitably trained and competent staff. Regulation 18 (1) (2)