Care Quality Commission

Heathcotes Care Limited

Heathcotes (Hucknall and Watnall)

Inspection report

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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?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service: Heathcotes (Hucknall and Watnall) is a residential care home for people with learning disabilities, and or autism and complex mental health needs. The care was provided across two homes; Hucknall unit and Watnall unit which was an all male residence. Care could be provided for up to 16 people in total. There were 14 people living at the home at the time of our inspection, 7 people in each of the units.

People's experience of using this service:
The overall rating for the service is inadequate and the service will be placed in special measures.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. 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. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration. 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 outcomes for people using the service did not always reflect the principles and values of Registering the Right Support. People's capacity to make decisions was not always clearly understood. This meant people were not always supported to have maximum choice and control of their lives and staff didn't always support them in the least restrictive way possible. They did not always have the restrictions used to support them to manage behaviour that challenges reviewed in line with the provider's procedures to ensure it was the least restrictive practice to keep people safe. Some incidents were not referred to safeguarding authorities as required to ensure a thorough investigation was completed. The provider's systems for assessing and reviewing the quality of the service were not always effective in highlighting these issues.
Staff did not always have the training required to safely support people. They did not always receive the support needed through supervision and regular team meetings to review their work and ensure they were effective in their roles. People's care plans were not always followed to protect people from harm and this impacted on their dignity. Referrals were not always made in a timely manner to ensure people received professional support to manage their health.
People were included in making choices around their care, with the support of advocates when required. They planned activities throughout the week and some of these had a clear goal; for example, increasing independence. People were involved in planning their meals and these were provided in line with specific

requirements. People had caring relationships with staff and felt they could trust them. Any concerns or complaints were managed in line with the provider's procedures.
The environment was adapted to meet people's needs and was clean and hygienic. The previous inspection rating was displayed in line with CQC requirements.
Rating at last inspection: The home was last inspected on 8 June 2017 and was rated good in all areas.

Why we inspected: We brought this inspection brought forward due to information of risk and concern.

Enforcement: We found the provider was in breach of four of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and one of Registration regulations (2009). You can see what action we told the provider to take at the back of the full version of the 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: Immediately after our inspection, we wrote to the provider and asked them to take urgent action to address the most serious risks outlined in this report. In response, the provider developed an action plan detailing actions taken and planned, to make improvements and reduce risk. Additional resources were also immediately deployed to the service. We also had a meeting with the provider to discuss our concerns and establish lines of communication to report ongoing improvements.

We will continue to monitor intelligence we receive about the service until we return to visit as per our re-inspection programme. If any concerning information is received we may inspect sooner.

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? The service was not safe. Details are in our Safe findings below.	**Inadequate**
Is the service effective? The service was not effective Details are in our Effective findings below.	**Inadequate**
Is the service caring? The service was not always caring Details are in our Caring findings below.	**Requires Improvement**
Is the service responsive? The service was not always responsive Details are in our Responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our Well-Led findings below.	**Inadequate**

Care Quality Commission

Heathcotes (Hucknall and Watnall)

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 in part by notification of an incident following which a person using the service sustained significant harm. This incident is subject to a criminal investigation and as a result this inspection did not examine the circumstances of the incident.

However, the information shared with CQC about the incident indicated potential concerns about the management of risk around behaviours which could challenge others. This inspection examined those risks.

Inspection team:
The inspection visit was completed by two inspectors, a specialist adviser and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service for people with learning disabilities. The specialist adviser had expertise in supporting people with learning disabilities and the management systems required to do so well. An assistant inspector also supported the inspection by telephoning staff who worked at the two homes.

Service and service type:
Heathcotes (Hucknall and Watnall) is a care home. People in care homes receive accommodation and personal care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service was assessed as meeting the principles that underpin Registering the Right Support and other

best practice guidance when it was registered with us. The principles reflect the need for people with learning disabilities and/or autism to live meaningful lives that include control, choice, and independence.

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. However, the registered manager only had responsibility for the Watnall unit and there was another manager in the Hucknall unit who had not yet registered with us.

Notice of inspection:
The inspection visit was unannounced.

What we did:
We used information we held about the home which included notifications that they sent us to plan this inspection. On this occasion the provider had not been asked to complete a Provider Information Return (PIR). This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. However, we gave opportunities for them to update us throughout the inspection.

We used a range of different methods to help us understand people's experiences. We spoke with eight people who lived at the home about the support they received. We also spoke with one person's relative about their experience. We spoke with the registered manager, the home manager, two team leaders and four care staff. The area manager and regional manager also attended the inspection and we spoke with them during the visit and at the feedback meeting. We reviewed care plans for eight people to check they were accurate and up to date. We also looked at medicines administration records and reviewed systems the provider had in place to ensure the quality of the service was continuously monitored and reviewed to drive improvement. These included accidents and incidents analysis, meetings minutes and quality audits.

We asked for additional information after the inspection and this was provided within the timescale. For example, we asked the provider to liaise with the safeguarding team and the local authority about referrals made and authorisations in place and they completed this and shared the information with us.

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. Regulations were not met.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong; Using medicines safely.
•□Risks to people's health and wellbeing were not always assessed, mitigated or reviewed to protect people from harm.
•□When incidents occurred which put people at risk of harm they were not always fully reviewed to assess the ongoing risk to people. Plans were not always put in place to manage this risk and staff were not given guidance on the best way to support people.
•□People had plans in place which assessed the risk of their behaviour and the potential harm to themselves. For some people one of the actions which could be taken to manage this risk was for the person to be physically restrained by staff. This should only happen in line with the plan. However, we found that one person was being physically restrained at a more intense level than the risk had been assessed as. This meant they were physically restrained by four staff rather than the two detailed in the plan. This put the person at risk of harm as there was no clear guidance for staff to use this technique with them. Although this incident had been reviewed by a manager they had not picked up on this which demonstrated the analysis of incidents was not thorough. It also demonstrated that the analysis of why this restraint was used and what purpose it served was not sufficient.
•□When people behaved in a way that could harm themselves or others the incidents were not always fully reviewed and analysed to understand what function they served for people. This meant that the system in place to assess the 'triggers' for people to behave in this way were not always followed and increased the risk of the behaviours being repeated. Learning from other incidents was vague and did not provide specific information to guide staff support. For example, after some incidents of behaviours that could challenge the member of staff reviewing them had written, 'Stay one step ahead'. This was unclear guidance, didn't review the behaviour thoroughly, and didn't seek to understand its purpose.
•□Some people had plans in place to promote their wellbeing which were not always followed. One person was behaving in a way that suggested they were unwell and professional support should be sought. However, this had not been recognised and a referral had not been made. This put the person at risk of potential physical and mental harm.
•□Some people had been prescribed medicines to take when needed to assist them to manage behaviours that could challenge. The guidance for staff about when people should be given this was not detailed enough. For example, for one person the guidance said the person should be given their medicine for 'agitation; may be displayed as shouting, swearing and physically attacking staff. They may also smash or throw items.' However, records showed that the person was sometimes given this medicine when they were less agitated than this. A member of staff we spoke with said that the person's GP had advised to offer the medicines 'pro-actively' to support them to be calmer before the escalation. This was not recorded in the medicines guidance or in their behaviour support plan.

• When incidents had occurred, they were not always reviewed to ensure that lessons were learnt and to avoid repetition. In Hucknall unit no incidents had been reviewed since January 2019 and therefore opportunities to analyse 'triggers' or trends had been missed. In Watnall unit the reviews were not always thorough enough. For example, one person was physically restrained in a position by two staff when four staff were needed to do this restraint safely. The incident report recorded there weren't enough staff to complete this restraint properly. There was no record of what action was taken to investigate this incident and whether staff received additional training to understand what they could do safely or if night staffing levels were adequate to support service users safely. The use of unsafe physical interventions put people at risk of harm.
• When significant incidents had occurred people's care plans had not always been reviewed as a consequence to ensure staff had up to date guidance to manage the potential risk or support their wellbeing. This placed them at risk of harm.
This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• The systems in place to store, record and manage other medicines were effective.
• People were administered their medicines in a kind and patient manner and we heard their medicines were explained.

Systems and processes to safeguard people from the risk of abuse
• People were not always protected from the risk of abuse because staff did not always follow the systems and processes in place to protect them.
• Some incidents had not been reported in line with the provider's procedure or local safeguarding arrangements. For example, one incident which put people at risk was not reported through the provider's weekly system and senior managers were unaware of it at the inspection visit. An investigation into the incident had not occurred and this meant people were not protected from potential harm.
• Another person presented with an injury which may have been caused when they were anxious or distressed. There was a delay in seeking medical attention for this injury. An investigation into the cause of the injury or delay in treatment was not completed. This meant the person was not protected from harm and possible neglect.
This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
• Staffing levels were planned around individual need. However, staff from Watnall unit told us that the levels in that home sometimes reduced to provide assistance in another nearby home owned by the provider. One member of staff explained that although the staffing levels did not go below 'safe' levels, it did mean that people sometimes had to cancel arrangements because there were not enough staff to provide safe support to the assessed level out of the home.
• The provider followed safe recruitment procedures to ensure staff were suitable to work at the home.

Preventing and controlling infection
• The homes were clean and hygienic. Arrangements were in place for using protective equipment when required to minimise the risk of infections.
• People were involved in maintaining their home; for example, cleaning up after a meal. One person told us, "I clean my own room, I like dusting. I can clean my room on any day."

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. Some regulations were not met.

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 provider 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.
• We found people were not always supported in the least restrictive way possible. After an incident which could cause potential harm to individuals an alarm was installed on one person's bedroom door. A member of staff explained to us that this was so that staff would know the person's whereabouts at all times. The person's ability to consent to this decision had not been assessed. The decision had not been made in consultation with other professionals or with the person's family to ensure it was in their best interest. There was no review date set for this restriction and no DoLS had been applied for to ensure it was legally authorised.
• One person had been physically restrained at a higher level of intervention than they had been assessed to need. This did not uphold their rights under the MCA.
• In Hucknall unit we were unable to establish which people who lived there had a DoLS in place on the day of the inspection visit. The staff we spoke with were unable to say who had one and who required one. We were told that one person had capacity to make their own decisions but when we checked their care records this was not in line with the assessments there. Poor organisation and the lack of staff knowledge posed a risk that people's rights under the MCA may not be protected.
This was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience
• Staff did not always have the training and support required to be able to effectively support people.
• When one person was physically restrained in a four person hold two of the staff involved had not been trained to perform that level of restraint safely. That placed the person and staff at risk of harm.

•□Some people living in Hucknall unit had a diagnosed health condition which they had not received training in. When we spoke with staff they were not able to explain how this health condition may affect people in a different way to other people they supported. We found this impacted on assessing one of the people's wellbeing as staff did not demonstrate an understanding of their health deterioration.
•□Staff told us they did not always have the training and skills required to support people when they worked in different homes because the people who lived there had specific, different needs to those in the home they worked in.
This was a breach of regulation 18(2) 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; Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
•□Peoples care was not always planned against best practise guidance and there was not always a clear assessment of their condition.
•□National guidance states that all restrictive interventions should be for the shortest time possible and use the least restrictive means to meet the immediate need for the person. This was not always evidenced when physical intervention was used and the follow up was not always thorough enough to ensure it was appropriate and the least restrictive required.
•□Some people's assessments defined their needs but care was not always delivered in line with them. For one person this meant that timely referral to other agencies had not occurred putting them at risk of harm. There was a delay in accessing medical care for another person also.
•□Other people told us they saw health professional regularly and were confident that they would be supported to organise appointments if it was required.
•□Some people told us they saw health professionals privately to discuss important things which they did not want to necessarily speak with staff about. They told us staff helped them to organise this.

Supporting people to eat and drink enough to maintain a balanced diet
•□People were supported to be involved in planning their meals. Some people had specific diets and they were supported with this; for example, on a weight loss programme or to follow their religion.
•□People had access to drinks whenever they wanted them.

Adapting service, design, decoration to meet people's needs
•□The environment was planned around people's needs and this meant that in some areas consideration had been given to furnishings etc to reduce the risk of harm if people behaved in a way which caused them or others harm.
•□People's rooms were decorated to personal taste and were private spaces where they could spend time undisturbed if they chose to.

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 have their dignity respected.

Respecting and promoting people's privacy, dignity and independence
• Staff did not always recognise or respond to people's changing needs and this had a significant impact on their wellbeing and dignity.
• Some actions of the management team had infringed upon people's right to privacy and the lack of organisational review into these meant these issues were not identified or addressed prior to our inspection.
• After a significant incident one person's care plan was not reviewed to give staff guidance in how to support them afterwards to ensure their dignity and self-worth were maintained.

Ensuring people are well treated and supported; respecting equality and diversity
• People told us they had good relationships with staff and trusted them. We observed friendly, supportive interaction throughout the inspection visit. One person told us, "The staff are good they know me and what I like and don't like." Other people told us about named staff they had good relationships with and felt they could open up to.
• A member of staff we spoke with said, "There is good team cohesion and a good team spirit because everyone who does the job actually cares and it does not just feel like a job."
• Some people told us how they were supported to follow their religion; for example, by attending their local mosque.
• Other people said they were supported with reading and writing or attending college to learn new skills.
• We saw there were compliments to the staff team from family members. For example, there was a card thanking the staff for supporting one person to buy them a Christmas present.

Supporting people to express their views and be involved in making decisions about their care
• People we spoke with were aware of their care plans and talked to us about their involvement in planning and directing their care.
• Some people had specific communication needs and staff understood this and supported them as required. For example, one person was more comfortable communicating their wishes through email rather than verbally and staff supported them to do this.
• Several people we spoke with told us they had support from advocates to share their wishes and to make decisions. An advocate is independent from the service provider and represents the individual.

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.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control
•People did not always receive the personalised care that had been planned for them.
•Some people had plans in place to ensure their wellbeing but these were not always followed.
•Care plans were not always updated in response to incidents to ensure the guidance staff received was relevant and current.
•However, other people's care needs had been assessed in detail and this included protected characteristics under the quality act; for example, culture and religion.
•People had activities planned throughout the week and they told us they were involved in planning them. One person told us, "I do exercise in my room and go to the gym once a week". Some of the people we spoke with said they would like to go out more often but they understood the need for staff support for certain activities. When we spoke with staff and the registered manager they described how they planned the additional hours people were funded for staff support and activities throughout the week with people. They understood this sometimes caused frustration for people but also said there was flexibility too when people had things they wanted to attend.
•Some people we spoke with had clear goals about their support and were being helped to develop skills to reach them; for example, travelling more independently or managing their own meals. One person told us, "When we go shopping the staff member trusts me to go around on my own to but stays near me if I need help. It works well."
•Information was shared in different formats throughout the homes to ensure people could understand; for example, using photos and pictures. This showed us that the provider had complied with the Accessible Information Standard. This was introduced to make sure that people with a disability or sensory loss are given information in a way they can understand.

Improving care quality in response to complaints or concerns
•People we spoke with told us they had good relationships with staff and managers and were confident to discuss any complaints or concerns they had with them.
•Complaints were clearly recorded and any actions taken to resolve them was recorded to demonstrate they had been responded to.

End of life care and support
•There was no one receiving end of life care when we inspected. However, people had been given the opportunity to discuss their wishes.

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.

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; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others
•□There were incidents which occurred which put people at risk of harm or abuse. When we asked about these incidents we were told by one member of staff that they had been reported to the relevant authority. We found this to be incorrect and therefore did not promote a culture of openness and transparency.
•□In addition, we were told by one member of staff that there had been no incidents of restraint in one home; however, when we reviewed records we found there had been several incidents since the start of the year, including one five days prior to the inspection visit.
•□The systems the provider had in place to monitor and improve the care and support people received had not been effective in highlighting the failings in Hucknall unit.
•□In this unit we found incidents had not been reviewed by the manger nor reported to the provider. Team meetings and meetings with people who lived at the home had not taken place regularly. Safeguarding referrals had not always been made when required nor referrals to other professionals. Team leaders had not received supervision from the manager since they started their job in September 2018. The provider's oversight and governance systems had failed to recognise this. This put people at significant risk of harm.
•□The registered manager for the location only had oversight of Watnall unit and did not manage or review care at Hucknall unit. This meant there were different standards across the two homes under one registration with CQC.
•□The provider last completed an audit of Hucknall unit in September 2018, there had been no review since then to support the new manager. This was not in line with the provider's policy. This failure to ensure adequate oversight of the service had a negative impact on the quality and safety of the service.
•□When significant incidents had occurred in the homes there was no clear organisational learning and some staff we spoke with did not feel there had been a presence from the provider's leadership team to support them in difficult situations.
This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

•□The provider and registered manager had not ensured that we had been notified of all incidents as legally required. Some of the incidents which occurred, such as safeguarding referrals, should have been notified to CQC in line with the provider's responsibilities under their registration. This is so that we can check people

were protected from harm by the actions the provider took. A failure to notify CQC has a negative impact on our ability to monitor the quality of services.
This was a breach of regulation 18 of the CQC Registration Regulations (2009)

• The previous inspection rating was displayed in the homes in line with our requirements.

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 18 Registration Regulations 2009 Notifications of other incidents Notifications were not always made in line with the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent When people lacked capacity to consent the provider did not always meet their needs in line with the Mental Capacity Act 2005 (MCA)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff had not always received the appropriate support, training and supervision to enable them to carry out their duties effectively.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People did not always receive safe care and treatment.

The enforcement action we took:
We issued a Notice of Decision under S31 to restrict admissions

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 People were not always safeguarded from abuse and improper treatment.

The enforcement action we took:
We issued a Notice of Decision under S31 to restrict admissions.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The systems in place did not ensure Good Governance of the service.

The enforcement action we took:
We issued a Notice of Decision under S31 to restrict admissions.