Heathcotes Care Limited

Heathcotes (Arnold)

Inspection report

Redhill Farm
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Nottingham
Nottinghamshire
NG5 8NE

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

Summary of findings

Overall summary

About the service: Heathcote (Arnold) Redhill Farm is a care home and accommodates up to 10 people with a learning disability and or autism and complex mental health needs. Nine people were using the service during the inspection.
The service consisted of one house with a self-contained flat within the house.
The care service has been developed and designed in line with the values that underpin the Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion. People with learning disabilities and autism using the service can live as ordinary a life as any citizen." Registering the Right Support CQC policy.

There was no registered manager in post at the time of the inspection and an interim manager was managing the service with oversight by senior managers. 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.

People's experience of using this service:
Risks associated with people's needs were not consistently and effectively managed. Assessments of people's needs were not always undertaken using nationally recognised tools to ensure consistent care.
Safeguarding issues were not always managed effectively to protect people and staff from harm. Incidents were not sufficiently reviewed and robustly analysed, to consider themes and patterns and how lessons could be learnt, and improvements made.
People did not always have consistent support to access their medicines should they need them. They were not always supported by enough staff sufficiently trained to manage their needs.
People's nutritional and health needs were not consistently met, their health needs, such as long-term health issues were not monitored.
Recent changes to the way the environment could be safely used meant people who lived at the service could not safely access some areas of the service.
People did not always receive support that met their needs. There was a lack of consistent up to date information in care plans to provide staff with the guidance to safely meet people's needs. Where there was guidance staff were not always following the information in people's care plans to provide safe consistent care.
Complaints were not always recognised and as a result not responded to in a consistent way, in line with the provider's complaints policy.
There was a failure by the management team to prioritise high risk work, and a lack of response to quality monitoring processes in place at the service. This impacted on several areas of people's care and resulted in a lack of oversight that was required to improve the quality of care provided for people at the service.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible: the policies and systems in the service supported this practice. They were

supported to express their views and opinions about their care. People had formed positive relationships with staff. There were safe recruitment processes in place.

Rating at last inspection: the rating at our last inspection was Good. We last inspected the service on the 10 March 2016.

Why we inspected: This inspection was because of concerns raised prior to our inspection.

Enforcement: We found the provider was in breach of three of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. 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: The overall rating for this service is 'Inadequate' and the service is therefore 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 act 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 act 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 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 always effective

Details are in our Effective findings below.

Requires Improvement

Is the service caring?

The service was caring

Details are in our Caring findings below.

Good

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

Heathcotes (Arnold)

Detailed findings

Background to this inspection

The inspection: We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team: The inspection was carried out by two inspectors and an assistant inspector who carried out telephone interviews.

Service and service type; Heathcote Arnold 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 did not have a registered manager in place at the time of the inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. 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 service manager in place was in the process of registering with the CQC we will continue to monitor this application.
Notice of inspection; This inspection was unannounced
What we did: We reviewed information we had about the service prior to our inspection. This included previous inspection reports, details about incidents the provider must notify us about, such as abuse and accidents. We spoke with the local authority quality monitoring team who work with the service.
During the inspection we spoke with three people at the service and three relatives by telephone to ask about their experience of the care provided.
We spoke with five members of staff on the phone, five members of care staff during the inspection days. We also spoke with the service manager, head of service and the regional manager.
We reviewed a range of records. This included five care records, medication records and three staff files. We also looked at the training matrix, audits, accident records and records relating to the management of the home.

Inadequate

Is the service safe?

Our findings

Inadequate: 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; Learning lessons when things go wrong

● The service did not always protect people from possible abuse. We saw two safeguarding incidents had occurred, these incidents related to behaviours of a person who lived at the service impacting on another person. The behaviour patterns were recorded in the person's pre-admission placement plan but had not been considered when planning the person's care. There was a possibility the safeguarding incidents could have been avoided had the information about the person been used to inform their care plan prior to the incidents.
● Although the safeguarding incidents were investigated and reported, the measures to reduce risks to people's safety were not implemented in a timely way. After the first incident some safety measures were introduced, however it was not until after the second incident that further safety measures went far enough to mitigate the risk to protect the person.
●There was a lack of robust reviews of safeguarding incidents at the service to support staff learning from incidents and accidents and reduce the risk of reoccurrence. For example, we reviewed an incident which had occurred involving a person living at the service which put staff at risk of harm. Discussion with the manager and the incident record viewed showed there had been no learning from this and the circumstances that allowed the incident to occur had not been reviewed. This placed staff at continued risk of harm.

Assessing risk, safety monitoring and management

●The risks to people's safety were not always assessed or mitigated. People did not always have up to date risk assessments in place to ensure any risks to their own or other people's safety were mitigated. This placed people and staff at risk of harm.
● One person had been admitted to the service from another Heathcote service. Their care plan had not been reviewed to establish if the measures in place at the previous placement were sufficient to keep both the person and other people safe at this service. The lay out of the service was different to the person's previous placement, and as a result some measures that were in place at the previous placement were not consistently in place at Heathcote Arnold.
● Risks associated with smoking were not managed safely putting people at the service at risk of harm through potential fire hazards. A person who was a known smoker had a risk assessment and care plan in place to safely support their smoking habit. The person was not meant to smoke in their room or have unsupervised access to a lighter. However, the risk assessment and care plan were not being followed, and during our inspection, on two occasions we saw the person had been smoking in their room unsupervised. This failure to manage risks associated with smoking increased the risk of fire.
●A further person had a deteriorating health condition that affected their mobility and continence. Their daily records showed they were unsteady when mobilising and had fallen a number of times in recent weeks. However, there was no fall risk assessment in their care plan, there was also a lack of measures in

place that would have supported the person with their mobility.
●The person was using a mobility aid; however, the manager did not know who had assessed this as being appropriate for use, or whether it was currently the best mobility aid for the person.
●The person also lacked a risk assessment to guide staff to manage their skin integrity. The person was incontinent, and their care plan noted they were at times reluctant to accept help to change themselves when they were wet. This put the person at risk of skin damage through moisture and pressure.

Staffing and recruitment

●People were not always supported by enough staff sufficiently trained to manage their needs. One person had been assessed as at times requiring a type of physical restraint which required four staff members. The training records we viewed showed that there were times when some staff supporting the person had not been trained to the required level to undertake this technique.
●The rota also showed at night there were not enough members of staff to manage an incident requiring this restraint technique and ensure other people at the service were appropriately monitored.
● We discussed this with the manager who told us this increased need had been supported by staff from other services in the Heathcote group. However, when staff had been sent from other services this had not always been recorded on the rotas. On several days, the staffing levels were recorded as lower than the established safe levels. This meant we could not be sure the levels of staff always met the needs of the people at the service.
● There were not always safe processes and procedures in place to support people with their medicines. The service did not always have a medicine trained member of staff on duty at night to administer as required medicines to people should they need them. These medicines included medicines to support people's anxiety and behaviour patterns. There was a lack of formal arrangements to mitigate this risk to people, the service manager told us the staff would call them if they required assistance. There was no written risk assessment or contingency plan in place for staff if the manager was not available.

The above evidence shows the provider is in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using Medicines safely
●Staff had information on people's individual preferences around their administration of their medicines and the records of administration were well maintained.
●Staff who did administer medicines had received appropriate training for their role. One staff member told us, they were regularly offered refresher training or support.

Preventing and controlling infection
● Staff showed a good knowledge of their roles in reducing the spread of infection using personal protective equipment (PPE) and handwashing.
●There were regular cleaning schedules to ensure the cleanliness of areas and equipment was maintained. People who lived at the service were also encouraged to take part in maintaining a clean environment.

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

RI: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.

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

●People did not always receive care in line with national guidance and standards. One person was at risk of tissue damage through incontinence issues. They had not been assessed using nationally recognised tools that would guide staff to ensure they received the most effective support. This increased the risk of the person developing tissue damage that could be avoided with appropriate monitoring by staff supporting the person.

● People received their care in line with the protected characteristics of the Equality Act 2010 which protected them from discrimination.

Staff support: induction, training, skills and experience

●The training staff received on people's health needs was variable. There was a lack of training for staff in some of these areas. For example, there was a lack of training for one person's health condition affecting their nutritional needs. However, some staff told us they had received training in other people's health needs. This meant people were not always supported by staff with the knowledge and skills to manage their health conditions.

●Staff had not received the required level of training in Non-abusive Psychological and Physical Intervention (NAPPI) needed to support some of the people living at the service. This could impact on the level of support people at the service needed to keep both them and others safe.

Those staff who had received the training told us how useful it had been in guiding them when managing people's behaviours in a positive way. One member of staff told us they had only needed to use physical intervention once "a long time ago" as the techniques they now used were very effective in calming people through talking to them and using distraction to manage any anxious behaviours.

●Staff did not always receive regular supervision to support them in their roles. The feedback from staff on the level of supervision they received was mixed. With some staff saying a lack of staff had impacted on the frequency of the supervision they received. The records we viewed showed the frequency of supervisions for staff were varied.

Supporting people to eat and drink enough to maintain a balanced diet

● One person had a health condition that affected their nutritional needs. There was a lack of guidance for staff on the person's condition and how they could effectively support the person. Records showed a lack of management of the person's daily eating habits. There was no evidence of support being sought from appropriate health professionals to manage the person's condition. This resulted in the person receiving inappropriate care for this condition.

●A further person's eating habits were variable and the person's care records showed on some days they only ate one meal a day. The daily fluid and food charts for this person were incomplete. We found no record of the person being weighed and there was no indication of how this aspect of the person's care was being managed. This meant there was a risk the person was at risk of unplanned weight loss.
●However, we saw other people at the service received appropriate support with their nutritional needs. Staff we spoke with were able to tell us about one person who required a specialist diet to support their cultural needs. Staff also told us they supported people to eat a healthy diet where possible. Staff told us they always listened to people's choices and introduced healthy food where they could.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
●People were not always supported to receive effective and timely care.
●There was a lack of timely referrals to appropriate health professionals when people's needs deteriorated or changed. One person's mobility had decreased and there had been no assessment undertaken by health professionals to establish what support the person currently needed in relation to their mobility. A staff member we spoke with said, "[Name] needs an OT (occupational therapist) to come and assess as [name] has [health condition] which is deteriorating." The manager told us they had requested a referral to the occupational therapy team via the GP, but we could find no evidence of the referral in the person's care plan or that the referral had been followed up.

Adapting service, design, decoration to meet people's needs
●While the service had been adapted to meet the needs of the people living there, a recent introduction of one person to the service had meant changes to the way the environment could be safely used. This had an impact on the rest of the people who lived at the service. At the time of the inspection most people who lived at the service were unable to access the garden. Their freedom to safely access the laundry room had been affected and there was no risk assessment to show how this was being managed for people. This meant the environment did not currently fully meet the needs of people living at the service.

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.
●We checked whether the service was working within the principles of the MCA and found they were. When a person was unable to consent to a decision, mental capacity assessments were completed. We saw assessments had been completed in areas that included people's ability to manage their own medicines. Best interest documentation was in place when a particular decision had been made for people.
●Staff we spoke with were clear on how they would support people to make their own decisions around their care. They told us they would use simple language and tailor the way they would ask questions to the individual to ensure they had the opportunity to choose how they wanted their care.
●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).
●DoLS applications had been made where necessary.

Good

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

Good: People were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; equality and diversity

- People and their relative told us staff were kind and caring towards them.
- People at the service were treated with respect by staff. Staff we spoke with were committed to supporting people live as independently as possible. One member of staff told us their job was to, "Support vulnerable adults and promote independent living. See (people) move on and go further in their lives." The staff we spoke with felt they had a good rapport with people at the service. They felt they worked well as a team to provide a caring environment for people.
- People's diverse needs were supported by staff. People's cultural needs were observed and incorporated into their daily lives. Throughout the service we saw there was accessible information for people to suit their need. Staff told us one person used a type of sign language or single words to communicate and their choices were well supported in this way.
- Throughout the inspection we saw staff treating people with respect, the interactions between people and staff were relaxed and positive.

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

- The care plans we viewed had detailed information about people's life history and what was important to them. We saw evidence that people had been offered the opportunity to be involved in planning their care. Staff we spoke with told us some people had also signed their care plans after discussing their care with them.
- Staff told us they worked with people to ensure their views were considered in the way their care was delivered. Staff were aware of the different support people needed to express their views. One staff member told us they would offer regular prompts and work to ensure people were as involved as they wanted to be.

Respecting and promoting people's privacy, dignity and independence

- People's privacy and dignity was prompted by staff. Although several people required one to one care, staff were aware of the need to offer people private time. One staff member said, "We always make sure they have their own space."
- Staff were aware of the importance of managing people's confidential information and not discussing people's personal details outside of work.
- Staff were aware of the importance of promoting people's independence, one member of staff told us they supported people but tried to get them to do things for themselves. They felt this was important to allow people to learn and develop.

Requires Improvement

Is the service responsive?

Our findings

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

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

Planning personalised care to meet people's needs, preferences, interests and give them choice and control

●People did not always receive support that met their needs. Records showed that one person had a health condition that affected their nutrition. Staff did not have sufficient skill or knowledge to provide support to meet the needs of this aspect of the person's care. Staff told us they did not have any training in relation to this health condition and told us they lacked knowledge in this area. The person's care plan for this aspect of care was not based upon professional advice, and lacked detailed guidance and rationale for staff on how to effectively support the person.
●Records we viewed showed that what guidance there was in the care plan was not being followed by staff, and they were not effectively monitoring this aspect of the person's care. Staff had no idea of the severity of the person's condition. This failure to seek expert advice, lack of clear guidance and ineffective monitoring put the person at risk of long term health conditions.
●A further person's records we viewed showed they were prone to self-neglect and gave staff information on how the person may present when their mental health deteriorated. There was no information on the triggers that may affect the person's mental health. This meant staff did not have guidance on how to avoid a deterioration in the person's mental health.
●The information in people's care plans was not always up to date and did not contain enough detail to guide staff to effectively support people in their care. One person had recently been admitted to the service and their care plan and risk assessments had not been updated from their last placement. There had been a significant incident which occurred at their last placement that had not been identified in their care records. There had been no assessment of the risks posed in the person's new environment, both environmentally or personally for the person and other people living at the service. Consequently, there was no written guidance about how to reduce risks.

The above evidence shows the provider is in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

●However, some people received personised care for some aspects of their daily lives. We saw examples of people being supported to undertake daily activities such as attending college courses or visiting family. People had input into the different activities they wished to take part in.
● Staff told us some people required prompting and motivation to take part in social activities, but with encouragement people could be supported to enjoy the different activities on offer. One member of staff discussed how encouraging different people to undertake social activities improved their mood and made them feel more positive in themselves. The member of staff felt this was important for the wellbeing of people at the service.

Improving care quality in response to complaints or concerns

● Staff were aware of their responsibilities if any complaints or concerns were raised to them.

●One member of staff told us they had not known of any complaints, but they told us if a person raised a complaint to them they would take notes of exactly what the person said and pass this on to a team leader or manager. The member of staff felt any concerns were dealt with in a professional and positive way.

●The manager was aware of the company's complaints processes and told us they would follow these processes should they have any complaints raised to them, they told us they had not had any complaints raised to them. However, relatives we spoke with told us they had raised concerns verbally with both the manager and staff but found there was a lack of timely responses to their concerns. They told us they needed to raise issues several times before staff responded to their concerns. The relatives felt communication could be improved so issues could be dealt with more promptly, as when they went back to staff they did not always know that the concerns had been raised.

●This showed that staff did not always recognise when people were raising complaints or concerns. They weren't recording and passing on concerns, so they could be dealt with in a timely way

End of life care and support

● People at the service had been offered the opportunity to discuss their end of life care. but no one at the service wished to discuss this aspect of their care at this time.

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

Inadequate: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; Continuous learning and improving care.

- There was a lack of oversight in relation to the quality monitoring of the service. There was a failure to prioritise high risk work. As detailed elsewhere in this report essential information was not present in people's care plans to guide staff to offer effective and safe support for people.
- Although the manager was aware of the lack of clear up to date information for staff on a range of care issues, and care plans did not reflect the needs of people in their care. They told us they had not had time to update the plans. The service had been using staff from other services within the provider group to support people, and this lack of clear up to date information placed service users and staff at risk of harm.
- There was a failure to act on quality audits in place at the service. For example, we saw a provider audit that highlighted issues with the level of information on people's daily records and incident forms, the manager told us they had addressed this with staff at a staff meeting. However, we found no record of the discussion on the minutes of the meetings we viewed. Incident forms we viewed also showed the manager had not acted on the issues highlighted at these audits relating to lack of robust information. Incident forms lacked manager comments to show if actions had been taken following an event, to debrief staff and learn from incidents.
- There was a failure to learn from serious incidents at the service, for example the safeguarding incident detailed elsewhere in this report. Also, an incident had occurred involving a member of staff supporting one person, the information clearly showed a risk to the member of staff. However, we saw no learning had taken place as the member of staff continued to support the person resulting a second incident on the same day,
- There was a lack of analysis of people's behaviours to look at trends, this had resulted in a continuation of behaviour patterns that were not conducive to people's health and well being

Working in partnership with others

- There was a failure to work effectively with health professionals supporting the service, one person had wished to purchase a potentially dangerous item. However, advice and information on how to safely and effectively support the person with this aspect of their care, that posed a potential risk to other people and staff had not been shared with staff. There was no information in the person's care plan. This failure to act upon professional advice placed staff and service users at risk of harm.

The above evidence shows the provider is in breach of Regulation 17 of the health and Social Care Act 2008 (Regulated Activities) Regulation 2014,

Planning and promoting person-centred, high-quality care and support; and how the provider understands

and acts on duty of candour responsibility

●The staff at the service were not always open and responsive to relatives' requests for information or the concerns they raised. Although relatives we spoke with told us they were aware of who they could talk to about their family member's care, one relative told us they had experienced an atmosphere at times after they had raised issues. Other relatives told us they sometimes had to ask several times about some issues before things were addressed. Relatives felt that communication could be improved as the service was not always proactive about feeding things back to them, and they were required to prompt staff for information.

●Staff knew who they would report any concerns to on a day to day basis and told us they would feel safe in doing this. One member of staff told us, "Yes they (managers) are definitely good leaders that are always there if you need to get anything of your chest."

●The service manager reported important events to us through notifications, so we could monitor how these events had been managed and ensure appropriate actions had been taken.

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

●Staff told us they felt involved and engaged in the running of the service. One staff member said. "Yes definitely." The staff member told us they had progressed a lot in their job role and been given opportunities to develop in their role.

● Staff told us they had regular staff meetings where their ideas on how to improve the service could be raised. The minutes of staff meetings we saw discussed the care needs of people at the service. However there had been no staff meetings following recent significant changes at the service. This meant staff did not have the appropriate information to support them in their roles to manage the safe care and treatment of the people they care for.