Heathcotes Care Limited

Heathcotes Grove House

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Heathcotes Grove House is a large detached house near the town centre. It is registered for the support of up to eight adults and children of 16 years and over. Support is provided for people with learning disabilities and other complex needs. One person was using the service at the time of our inspection.

The service is bigger than most domestic style properties and is larger than current best practice guidance. However, the size of the service having a negative impact on people was mitigated by the building design fitting into the residential area and the other large domestic homes of a similar size. 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.

People's experience of using this service and what we found
Systems in place had not always protected people from abuse. People had not been asked if they felt safe or what they could do if they worried or concerned. A relative told us they did not feel their family member was always safe at the service. Staff told us they had not felt safe when incidents happened at the service.

The provider had not always dealt with incidents appropriately to minimise people's risks. Some restrictive practices had been in use that were not in line with current legislation and national guidance and staff had not received training in this area.

People were not always helped to communicate their needs. Although guidance had been given to staff about ways to communicate with people, information was not always available to people in a format they could understand.

Risk assessments in place were detailed and person centred. However, people's individual risks related to COVID-19 had not been identified. Medicines were not always managed safely. Medicine records were poor and this meant it was hard to tell what medicines people had received. During our inspection we found the provider had identified issues with people's medicine records and had started to make changes to put things right.

Staff did not follow safe infection prevention and control practices or follow up to date COVID-19 guidance to help stop the spread of infection.

Staffing numbers were adequate but new staff were covering shifts, without adequate training. There were periods where no senior leadership was in place and staff rostered to work did not always have the skills and knowledge they needed to support people. This meant people were at risk of unsafe care and treatment.

Governance arrangements at the service were not sufficient or robust enough to monitor and assess the

quality and safety of the service or the welfare of people. Staff did not receive effective support from the management team to keep people safe. The lack of robust management meant there was no consistent oversight of the service.

The quality of care people received had deteriorated since our last inspection. The provider failed to act on all of the concerns we raised previously or to learn lessons when things went wrong. Where improvements had been made, they were not adequately embedded within the culture of the service.

Rating at last inspection
The last rating for this service was requires improvement (published 28 January 2020).

Why we inspected
We received concerns in relation to the reporting of incidents and how these were acted upon, infection control procedures and risk management, medicine management and lack of staff training and skill mix. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

The overall rating for the service has changed from requires improvement to inadequate. This is based on the findings at this inspection. Please see the safe and well-led sections of this full report.

You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Heathcotes Grove House on our website at www.cqc.org.uk.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified four breaches in relation to safeguarding people from the risk of abuse, keeping people safe, staff training and allocation and how well the service is managed at this inspection.

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

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

Special Measures
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 the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the 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?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Heathcotes Grove House

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked 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
One inspector visited the service on 23 June 2020 and some of the inspection was carried out via a video link on 01 July 2020.

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

The service had a manager registered with the Care Quality Commission. The registered manager and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
We gave a short period notice of the inspection because we wanted to be sure that the provider or registered manager would be in the office to support the inspection.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During the inspection
We spoke with the registered manager, the regional manager and the operational director and three staff members. When people who used the service were not able to speak to us about their care experiences we observed how the staff interacted with people in communal areas. We looked at two staff files, people's medicine records, accident and incident records, daily notes and quality assurance records. To reduce the amount of time we spent at the service we conducted part of our inspection over a video link and asked the registered manager to send us more information following our visit.

After the inspection
We spoke to two relatives of people who used the service to find out their views. We spoke to four staff members and the local authority. We continued to seek clarification from the provider to validate evidence found.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse
• People were not always kept safe from the actions of other people using the service. We spoke with one relative about incidents that had occurred at the service involving their family member and another person using the service at the time. Although they praised the staff supporting their family member they also discussed their past and ongoing concerns about new people joining the service. They told us, "[My relative] is not safe at the moment, I don't think you could classify this as safe. Could you guarantee safety with anyone else at the service?" We also heard from one member of the public who had raised concerns about the service and how people were being supported.
• People did not always have the support they needed to raise concerns or tell staff when they did not feel safe. When people were unable to communicate their feelings verbally there had been limited attempts to involve and support people to reflect their worries and concerns. One person required the use of additional communication aids such as pictures and talking tiles to help them communicate but these were not easily accessible and in some instances had been broken. On the day of our inspection we tried to use the talking tile on the medicine room door. This was there so the person could tell staff when they were in pain, however, it was not working. The registered manager told us it had been broken by another person who had used the service and another one was on order. When incidents had occurred we noted there had been no attempt to establish one person's feelings and if they felt safe.
• People were at risk of harm because staff lacked the skills and knowledge they required to manage people's behaviours safely. Staff told us that they did not always feel safe in some situations when people's behaviours challenged the service. Although positive behaviour support plans gave guidance to staff on what restrictive techniques to use safely should a person's behaviour escalate, we were concerned without training in this area staff would not know how to perform these techniques safely when required.
• All of the staff we spoke with during our inspection understood the signs of abuse and what to look for. However, where restrictive practices were required to keep people safe these were not always provided in line with current legislation and national guidance. This became apparent following an incident at the service where staff suffered injuries and one person was restrained following an escalation in their behaviour.
• Although the provider was open and transparent regarding the reporting of the incident we were concerned that some issues were still continuing from our previous inspection in 2019 and lessons had not been learnt. This meant people's safety and staff safety was at risk because systems and processes were not followed to make sure staff had the skills knowledge and experience to keep people safe.

The issues above were a breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management

• People had risk assessments in place giving staff the information they needed to help keep people safe. However, people's individual risks had not been assessed in relation to the COVID-19 pandemic and some information to guide staff was not clear. For example, one person had visited the shops in May 2020, during lockdown, but there was no guidance in place to advise staff on what they needed to do to keep that individual safe. The registered manager had put a risk assessment in place for another person using the service during June 2020 but we found the guidance on this conflicted with the service's general risk assessment in place for COVID-19. We were concerned because people using the service may be at a higher risk of infection but staff did not always have the guidance they needed to reduce this risk.

• People had positive behaviour support plans in place, however, these had not always been reviewed regularly by appropriate healthcare professionals. For example, following an incident in May 2020 the registered manager informed us that one person's care plan would be reviewed by Heathcotes' clinical psychologist. However, we could not see evidence of this being completed during our inspection. We were concerned because staff needed this information to respond to people's changing needs to help keep them safe. After our inspection the provider explained Heathcotes clinical psychologist had contacted the service to arrange a meeting. However, following an escalation in the person's physical behaviour the service served them notice and the person moved out two weeks later so the review had not been completed.

Using medicines safely

• Medicines were not always managed safely. The local authority had visited the service in June 2020 and reported their concerns about medicine management to us. When we looked at people's medicine administration records (MARs) we found they contained incorrect dates and inaccurate information. For example, the dates when one person had received their 'as required' or PRN medicine was recorded incorrectly. After the inspection the provider sent us additional information and written confirmation of the prescription change to one person's medicine. However, we remain concerned that medicine records were unclear and incorrect in some areas.

• All staff had received on-line training in medicine safety. The provider's face to face training in safe handling of medication had not been available to staff because of COVID-19. We found staff competencies were being undertaken in medicine management. However, at least two examples indicated new staff members employed as support workers were conducting medicine competency checks for other new staff members. Although records indicated the registered manager started to oversee competency checks soon after the visit from the local authority, we were concerned the systems in place up until this point were poor and did not provide assurance that staff had the knowledge and skills they needed to administer people's medicines safely.

Preventing and controlling infection

• The service did not always have robust systems in place to protect people from the risk of infection. Following the outbreak of COVID-19 staff had not been trained in relation to infection control procedures. Although the registered manager had assured us that staff had been notified about changes and updates in government guidance we were not assured that staff fully understood the risks to people using the service. The local authority visited the service in June 2020 and found staff were not wearing masks. This was contrary to the government guidance in place at the time.

• During our inspection staff were wearing masks. There seemed to be some confusion over the wearing of protective plastic aprons as one person's risk assessment had identified plastic aprons as a risk. When we asked for clarification we were told the service had ordered fabric aprons for staff to help reduce risk, but these were on order and had not arrived. We were concerned about the lack of knowledge and clear guidance available for staff around the risks associated with wearing certain protective equipment to reduce the spread of COVID-19 and the impact this could have on people.

• Staff told us they had not received training in infection control but were aware training had been booked.

Staff told us they cleaned surfaces and door handles as part of their daily cleaning schedule but two staff members were not aware if this was normal procedure or because of the pandemic. One staff member confirmed staff had not been wearing masks until recently and although staff had not received any training they thought they had taken a "common sense" approach to the use of personal protective equipment (PPE). We were concerned because government guidance had not been followed, there were delays in taking appropriate action and staff had not received appropriate training.

Learning lessons when things go wrong

• Staff did not always feel confident in reporting incidents when things went wrong. Although one staff member felt they could speak to the manager about concerns they told us they had not had training in how to complete records such as daily records or incident reports until recently. When we checked records staff training in report writing was provided to most staff in June 2020. This meant new staff members may not have recognised when they needed to report or record an incident. After our inspection the provider told us staff training for record keeping was normally provided during staff induction, however, this had been cancelled because of COVID-19. The provider had identified issues with staff record keeping and had addressed this by providing training to staff on 22 June 2020.

• During our inspection in May 2019 we raised concerns that not all incidents were being reported to managers, at the time improvements had been made to make sure lessons had been learnt. Before this inspection we had received concerns that not all incidents had been reported and some reports were being changed. At this inspection we found one incident report had been written by the registered manager after the event. After the inspection the provider told us this was because the original incident report had not been clear. Although there were additional staff statements attached there was no clear audit trail to show who had completed the incident form and when. This level of information is important to give assurance that incidents and near misses are recorded and responded to appropriately. The provider assured us staff reported all incidents and near missed to the registered manager.

The issues above were a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

• The service did not always have enough staff with the right mix of skills, competence or experience to support people to stay safe. People using the service had complex needs and the provider had recognised the need for an experienced senior staff member to be on shift at all times. This was identified as an action following our inspection in 2019. The service had employed five new staff members between March and June 2020 and there was a period between 21 May and 22 June when there were no experienced team leaders in place. This meant there were several occasions over this period where new, untrained staff on duty. This meant staff may not have received the support they needed to meet people's needs and keep people safe.

This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now deteriorated to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

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

• A new manager had joined Heathcotes Grove House during November/ December 2019 and was later registered by the CQC in June 2020. The registered manager was supported by a regional manager and an operational director. All three were present on both days of our inspection.

• During our inspection in May 2019 we found quality assurance systems in place had failed to identify issues that had impacted upon people's safety. When we inspected in December 2019 we found the provider had made improvements and this had given us assurance at the time. However, the provider had been unable to maintain the improvements made and during this inspection we found shortfalls in the way the service was managed. The providers quality assurance program had been limited by the outbreak of COVID-19 and although they had identified some of the issues highlighted in this report during their last audit in April 2020 improvements at the service had not been always been made.

• New staff had been employed by the service but essential training to keep people and staff safe had not been provided. For example, specific training required for people's care, training for staff to safely manage behaviour that may challenge the service and infection control training relating to COVID-19.

• New staff were rostered on shift without the knowledge and skills of more experienced staff to help and guide them putting people at risk of inappropriate care.

• Record keeping was poor, daily notes contained gaps and were sometimes poorly completed. Incident reports were not always completed by the staff member on shift at the time and sometimes contained conflicting information. Medicine errors had not been identified and new staff members had been supervised by other new staff for medicine competency checks.

• People's risk had not always been identified and recorded. Although the service had a generic risk assessment in place for the COVID-19 pandemic, individual risk assessments were not in place at the time of our inspection. This meant guidance was not in place for staff concerning people's individual risk concerning infection control, personal protective equipment and access to the community.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong; continuous learning and improving care; engaging and involving people using the service, the public and staff, fully considering their equality characteristics; promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

• People's relatives told us they knew who the registered manager was and had mixed feelings on the governance at Grove House. One relative told us, "[The registered manager] is good the care staff are good

but everything else is falling apart. They don't seem to learn from their mistakes." Another relative told us their concerns about the lack of staff training and the delay in communicating important events concerning their family member.
• During our last inspection we were told how much work had been completed improving the culture of the service and making sure staff were confident reporting concerns and speaking up. During this inspection staff told us they were able to raise concerns and felt the registered manager listened to them.
• The registered manager and the provider were working closely with the local authority following safeguarding concerns that had been raised. However, on this inspection we found concerns identified during our inspection in May 2019 were still current. This did not give us assurance the provider had learned lessons or made sure the improvements they had made to keep people safe were consistent and embedded into the culture of the service.
• Some people's needs had been overlooked and equality characteristics ignored. We could not see any culturally significant events or activities highlighted in people's care plans. When people were unable to verbally communicate we were unable to evidence how people were able to raise concerns because any aids to communication were not easily accessible and in some instances had been broken.
• At our inspection in May 2019 we had concerns the mix of people using the service had not been considered and this had compromised people's safety and wellbeing. Since this inspection the number of people using the service reduced from five people to one person. During this inspection the operations director and the registered manager spoke about the procedures in place to make sure any new person moving to Heathcotes Grove House had a full assessment and transition period. This would involve people living at the service and make sure their views and support and care needs were considered. We were told these procedures had been 'tried and tested' at other Heathcotes services with good outcomes for people. However, at the time of our inspection we were not able to gain assurance that these procedures would be effective for Heathcotes Grove House.

The issues identified above amounted to a breach of regulation 17 (Governance) of the HSCA 2008 (Regulated Activities) Regulations 2014.

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

This section is primarily information for the provider

Action we have told the provider to take

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

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

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not always assess, monitor and improve the safety of the service. The provider did not always identify risk to people. The provider failed to keep accurate and up to date records. Regulation 17(1),(2)(a)(b)(c).

Regulated activity	Regulation
Accommodation for persons who require nursing or	Regulation 18 HSCA RA Regulations 2014 Staffing

personal care	The provider did not deploy sufficient numbers of suitably qualified, competent, skilled and experienced staff to meet the needs of people. Staff did not receive the appropriate training and support to carry out the duties they were employed to perform. Regulation 18 (1) (2)(a)