Heathcotes Care Limited

Glenfield

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Heathcotes (Glenfield) is a residential care home providing personal care to up to 6 people. The service provides support to younger adults with a sensory impairment, physical disability, mental health needs and/or a learning disability or autistic spectrum disorder. At the time of our inspection there were 6 people using the service.

People's experience of using this service and what we found
We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it.

Right Support
The service did not give people care and support in a safe, clean or well-maintained environment that met their sensory needs. People's risks associated with their health conditions were not met safely. Medicines systems and processes were unsafe. People were not always supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not always support this practice.

People were supported to pursue some interests within the community when staff were available to accompany them. There were times when there were not enough staff available for people to go on outings.

Right Care
The service did not always have appropriately skilled and competent staff to meet people's needs and keep them safe. People did not always receive care that was focused on their quality of life or followed best practice.

The staff knew individuals well and respected people's rights and choices. Staff could identify people's communication needs and explain these; however, they weren't always well documented. Some care and support records contained out of date information, but staff were aware of the individuals needs.

Right Culture
The provider's quality assurance, governance systems and processes to monitor the quality and safety of the service failed to identify areas where improvements were required. This exposed people to the avoidable risk of harm and poor-quality care.

The staff knew and understood people well, however people's wishes, needs and rights were not always at

the centre of everything they did. People were not always supported by staff who understood best practice in relation to the wide range of strengths, impairments or sensitivities people with a learning disability and/or autistic people may have.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk
Rating at last inspection
The last rating for this service was good (published 04 December 2018).

Why we inspected
We received concerns in relation to the management of medicines and people's specific health care needs. As a result, we undertook a focused inspection to review the key questions of safe, effective and well-led only.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.
The overall rating for the service has changed from good to inadequate based on the findings of this inspection. We have found evidence that the provider needs to make improvements. Please see the safe, effective and well-led sections of this 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 (Glenfield) on our website at www.cqc.org.uk.

Enforcement
We have identified breaches in relation to Deprivation of Liberty Safeguards (DoLS), risk management, infection control, medicines management, staff training and leadership and governance at this inspection.

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

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

Follow up
We will request an action plan from 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 continue to monitor information we receive about the service, which will help inform when we next inspect. 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 effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Glenfield

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 Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
Two inspectors carried out the inspection.

Service and service type
Heathcotes (Glenfield) is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Heathcotes (Glenfield) is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager in post. However, the registered manager had been absent for just under 6 weeks, the provider had appointed an interim manager to oversee the quality and safety of the service.

Notice of inspection

This inspection was unannounced.

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. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with 7 staff members including the covering manager, compliance officer, head of service, area operations manager, head of estates, team leader and care staff. We observed staff interactions with 5 people who could not verbally communicate with us. We observed their body language during their interactions with care staff to further help us understand their experience of the care they received. We also spoke with a professional visiting the service.

We reviewed a range of records. This included 4 people's care records and 3 peoples medicines records We reviewed 4 staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures, audits, training data, cleaning schedules and environmental checks were reviewed.

We used the Quality of Life Tool which is designed to support the corroboration of all sources of evidence gathered during inspection.

Inadequate

Is the service safe?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

- Positive behaviour support (PBS) plans were in place for people. A PBS plan assists a person to develop positive behaviours to replace or reduce dangerous or distressed behaviours. The covering manager told us, not all staff were aware of all information within the PBS plans and that the techniques and strategies were not always followed. They stated, 'we need a staff meeting to recap [the PBS plans] with new staff and to ensure that all areas of PBS plans are understood and followed on the floor'.
- We observed several occasions where PBS plans were not being followed. This resulted in an increased risk of people's behaviour escalating resulting in harm to themselves, staff or other people.
- The outside environment was poorly maintained with broken equipment and unlocked storage facilities containing harmful materials such as gardening equipment and open tins of paint. There was a risk people would be harmed by equipment or ingesting hazardous substances.
- Risks relating to people's healthcare conditions were not always safely managed. Care plans, and risk assessments, failed to instruct staff of the action they needed to take should people's health needs deteriorate. Staff failed to follow one person's care plan to closely monitor their condition. This meant there was a risk of their health condition deteriorating.

Preventing and controlling infection

- The provider failed to ensure people were living in a clean environment. One person's bedroom had a stained en-suite with black mould present. The communal hallways, kitchen, bathroom and lounges had a build-up of dust, dirt, stains and spillages. This meant people were at increased risk of contracting infection as there was a failure to ensure effective Infection Prevention and Control (IPC) practices throughout the home.
- There were not enough staff deployed to ensure the service was cleaned effectively. The covering manager told us staff were required to clean areas of the home between their caring duties if time allowed. We observed due to individual people's needs staff did not always have time to undertake cleaning.
- We discussed our concerns about the cleanliness of the service with the covering manager and head of service. A 3 day deep clean was conducted. The inspection team visited the service after the deep clean, and whilst some improvements had been made, there were still unclean areas which posed an infection risk to people.
- The provider failed to ensure staff practices promoted good infection prevention control to reduce the risk of the spread of infection to staff and people living in the service. Staff did not wear personal protective equipment (PPE) in line with the national guidance. Staff were observed on several occasions either not wearing a mask, wearing the mask under their chin or below their nose. This meant the PPE was not fully effective and there was a risk infection would be more transmissible.

Visiting in care homes

● There was a visiting policy in place, however this was not always followed by staff members. The inspection team were not asked to sign in or out when visiting the service and their identification was not checked.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong

● The provider failed to ensure people were protected from abuse and improper treatment.

● Some people living at the service presented risks to staff, themselves and each other. People who required continuous supervision to reduce these risks did not always receive this. People were observed on their own during the inspection with team leaders and the covering manager unaware of where allocated staff members were.

● A system was in place to log all accidents and incidents and record lessons learnt for each instance. Although a system was in place, there were limited details recorded and no evidence lessons learned had been communicated to staff, particularly new and agency staff.

Using medicines safely

● Medicines were not managed safely.

● Medicine administration records (MAR) and care records relating to medicines contained inconsistent and contradictory information. One person had an unstable health condition that required close monitoring and medicines doses adjusting. Their MAR had been handwritten, the dosages on the MAR contradicted the information recorded in their care records and there was no audit trail evidencing why the dosage had been changed. There was a significant risk this person was receiving the incorrect dosage of their medicine putting them at serious risk of harm.

● Medicines were not always safely stored. The medicines fridge was dirty. There were a number of boxes of open medication that had not been labelled as open, it was therefore not clear which were in use. We found an out of date box of medicine in the medicine fridge. There was a risk this could be administered, which would have put the person at risk of harm due to the effectiveness being impacted.

● The provider failed to ensure staff administering medicines were skilled and competent. Staff administering insulin had not been trained to do so by a healthcare professional and there had been no competency assessment to ensure they had the skills and knowledge to administer this.. In addition, there were no competency assessments completed for the administration of specific medicines related to epilepsy or allergies.

● Medicines administration records had not been transcribed in line with best practice guidance. There was a risk people were not receiving their medicines as prescribed.

● The provider informed the inspectors that weekly medication audits were undertaken. However, records evidenced that medicines audits had not been undertaken since 09 September 2022. This meant the concerns we found during inspection had not been identified.

There was a lack of robust systems and processes to demonstrate safety was effectively monitored and managed. This placed people at significant risk of harm. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● There were no visiting restrictions in place, but staff told the inspectors that most visitors took people out for their visits rather than visiting the home.

Staffing and recruitment

● Staffing levels did not always meet the needs of people living in the service. Staff members told the

inspection team that there were not always enough staff to provide the required one to one support for people. During the inspection, there were periods which felt chaotic due to staff being responsible for multiple tasks.

● The provider carried carry out pre-employment checks on new staff members. This included obtaining a reference of character and conducting a DBS check. A DBS checks: Disclosure and Barring Service (DBS) checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions. However, there was 1 staff member who continued to work with an out of date DBS check which did not align with the provider's internal procedures

● This matter was raised with the head of service and area operations manager who completed a risk assessment and removed the staff member from working alone with people until an up to date DBS check had been obtained. This had not been identified by the internal systems in place.

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.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

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 MCA 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 when this is in their best interests and legally authorised under the MCA.

In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA.
- We found the service was not working within the principles of the MCA.
- Records demonstrated restrictive practices were used without having an updated mental capacity assessment or best interest decision in place. The provider failed to seek advice from healthcare professionals as to whether the restrictive practices would have an impact on peoples wellbeing or behaviour.
- The provider applied a blanket restriction to all people living at the service, due to one person's dietary needs. They failed to consider how this restriction would impact other people residing at the service.
- Records evidenced that DoLS had been appropriately applied for.

We found no evidence that people had been harmed, however, due to the failings in applying the mental capacity act, there was a risk people's rights would not be upheld and their freedom would be unlawfully restricted. This was a breach of regulation 11 (Need for Consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Staff support: induction, training, skills and experience
- Records evidenced that most staff had completed an in-person classroom based mandatory induction when commencing their employment. There were also several electronic learning courses and online training modules.

● Staff supervisions were being undertaken, however there were several staff members who had not been recorded as receiving any supervision or competency checks in 2022.
● Not all staff had received training in key areas including; supporting people with a learning disability, autism, epilepsy and diabetes. Additionally, systems were not in place or robust enough to ensure that training had been delivered and staff competency assessed. This put people at risk of inconsistent and unsafe support.

Systems to ensure people were supported by competent and skilled staff were ineffective. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to eat and drink enough to maintain a balanced diet
● The provider was unable to evidence that they were correctly following a diet plan implemented for 1 person. Instructions for the restrictive diet plan were incorrect, staff did not understand the requirements of the diet and were not supporting the person to eat enough.
● There were food and fluid charts for people within the service. These charts were blank or contained gaps. We could not be assured that the service was adequately monitoring the food and fluid intake for service users.

Adapting service, design, decoration to meet people's needs
● The physical environment did not meet the needs of the people using the service. The walls were bare, there was no personalisation and it did not feel homely. The television in the lounge was broken, and whilst the manager had ordered a new television, it did not fit in the existing cabinet so there was no television for people in the communal lounge.
● Many people would have benefited from sensory items being available. On the third day of inspection, a sensory board had been brought into the service. However, there was no implementation of the board by staff and it had been propped in the hallway causing a potential trip hazard.
● One person's PBS plan clearly stated that they should be encouraged to use the garden swings. During the inspection the swings were found to be broken and out of use. Whilst this had been identified in environmental checks no action had been taken to address this.
● The inspection team were provided with a site visit works schedule report completed on 04 October 2022. The report detailed the scope of renovations required at Heathcotes (Glenfield). The provider was in the process of identifying contractors to undertake this but were unable to advise of a timescale for completion of the works.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
● Records indicated that some health professionals had been consulted about people's health care needs, but care plans and health action plans were not always updated. In one person's file, we found information from a hospital consultant that was 2 years out of date.
● Visitor records evidenced that some health care professionals visited the service regularly.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● Care was not always delivered in line with best practice standards, guidance and the law. For, example National Institute for Care and Excellence (NICE) guidance for managing medicines in care homes was not followed.
● All of the care plans we reviewed were personalised. They included photographs and details of things people liked, and things that were important to them. Some care plans contained out of date information.

The area operations manager advised the inspection team that all care plans were in the process of being updated.

● Care plans contained easy to read guidance which could be easily understood by people. One care plan we reviewed contained pictures to demonstrate the persons preferred routine.

● Staff told us about people's individual preferences and knew people well. One staff member said "I know [Name of person] well, they like to go to the pub, go on day trips and can communicate their needs with hand signals which we understand".

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 our last inspection we rated this key question good. At this inspection the rating has changed 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

- The provider failed to effectively monitor the quality and safety of the service. The providers quality assurance systems and processes failed to identify the serious concerns we found in relation to managing people's healthcare needs and medicines. These put people at significant risk of harm and improper treatment.
- Furthermore, internal audits undertaken within the service failed to identify the concerns we found in relation to risk management, restrictive practices and staff competencies. The failure to ensure these arrangements were effective significantly restricted the providers ability to identify risks and shortfalls and exposed people to the avoidable risk of harm and poor-quality care.
- The registered manager had been away from the service for an extended period. The provider had put a covering manager, compliance officer and area operations manager in place to provide oversight and support to the staff and people. The absence of the registered manager contributed to the failings we found, there had been a lapse in some audits being undertaken since their absence.

Continuous learning and improving care

- The remedial actions taken by the management team in response to IPC concerns we found were insufficient. Despite a 3 day deep clean taking place, there remained areas of the home that were visibly dirty and unclean. The lack of action taken by the management team placed people at continued risk of infection.
- It could not be evidenced that regular checks on the cleanliness of the home were being carried out by the management team. This failure to ensure infection prevention and control measures were effective, exposed people and staff to an increased risk of infection.
- The provider did not have an effective system in place to ensure lessons were learnt following incidents and accidents at the service to reduce the likelihood of them reoccurring.. We reviewed completed accidents and incidents forms and found there had been no lessons learned documented from 14 September 2022 onwards.
- Prior to September 2022 where there had been a review of incidents and accidents, the lessons learned contained general statements such as 'personal care known trigger' and 'agitated at handover'. These statements did not provide any insight into the matter and do not provide insight in to why an incident occurred or how it may be avoided in the future. There was no evidence to demonstrate learning from incidents and accidents had been communicated to staff or that debriefs had taken place. Effective analysis

had not taken place demonstrating a failure to learn from incidents putting people at ongoing risk of harm.
● There were multiple folders in place containing people's records which led to difficulty locating and accessing information throughout the inspection. Staff members were unsure which folders contained the requested information. Information was duplicated across systems, which lead to inconsistencies when people's needs changed and not all records were up to date. There was therefore a risk people would receive incorrect care as not all records were up to date.
● The covering manager and quality director acknowledged that staff competencies had not been adequately assessed, and this matter had not been identified through internal provider quality assurance systems, meaning staff had been undertaking tasks without having been assessed as competent to do so. The provider failed to ensure there was sufficient oversight and monitoring of staff skills and competencies required to provide safe care and treatment.

Quality assurance systems and processes failed to effectively assess, monitor and improve the quality and safety of the service. This was a breach of Regulation 17 (good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● The culture of the service was positive, and people were supported to be independent and pursue activities they enjoyed. One person had an interest in planes, and so visited the airport frequently. Another enjoyed baking, so was supported to make cakes in the communal kitchen.
● Staff told the inspectors that they enjoyed working at the service and felt supported by their peers and the management team. Three staff we spoke with were knowledgeable about the people using the service and supported them to achieve their desired outcomes.
● People had representatives, relatives and advocates who were given the opportunity to provide feedback to the service. We reviewed the providers complaints and compliments records and there have been no complaints raised about the service or the standards of care provided in the last year.

Working in partnership with others; 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
● Staff worked openly with other health professionals. the registered manager and staff were not always able to identify When things went wrong. When these instances were identified, appropriate alerts were made.
● The management team understood their responsibilities under the duty of candour.
● We discussed the areas of concerns within care delivery, governance and leadership with the provider. The provider responded to the concerns identified with an action plan, which gave us assurance the provider was committed to driving improvement in leadership and care delivery in the service.