Heathcotes Care Limited

Heathcotes Chesterfield (Pennine House)

Inspection report

Pennine House
Cuttholme Way
Chesterfield
Derbyshire
S40 4WG

Website: www.heathcotes.net

Date of inspection visit:
16 August 2018
24 August 2018
29 August 2018

Date of publication:
20 December 2018

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

Pennine House is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Pennine House is registered to accommodate eight people in one building. On the day of our inspection there were six people living in the service.

We inspected the service on 16, 24 and 29 August 2018. The inspection visits were unannounced on all days. This was the first inspection of the service.

The service did not have a registered manager. There had been no consistent management of the service since it opened in August 2017. 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.

The provider has breached regulations, you can see what action we told the provider to take at the back of the full version of the report.

People were not always kept safe through the use of effective care planning, risk assessment and management. There was not always sufficient trained staff who were given clear directions on how to care for people, and had their performance was reviewed and managed. While staff were aware of their duty of care to keep people safe they did not act on this appropriately.

Staff were not deployed in the best interests of people and they worked very long hours without a break. Records did not always reflect what was happening in the service such as staffing levels and staff hours worked. Records were not always stored safely. The service was clean and fresh and there were processes in place to keep the service infection free.

Medicines were stored and administered as prescribed. Staff endeavoured to ensure they had the person's consent to care for them. However this did not always happen and people were not always consulted on how they wanted their care delivered.

Care plans were not always up to date and reflective of people's needs and wishes. This impacted on the risks to people as up to date information on risk was not always available. Due to the lack of consistent management, communications were not always effective.

People's dignity was promoted and staff were caring in their interactions with people. However peoples' independence was not promoted as there was not always enough staff to ensure they had an active social life outside the service.

There was a complaints process in place. There was a quality assurance process in place. However it was ineffective and had not reflected the concerns raised during this inspection process.

The home has been rated inadequate and has been put in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

This service will continue to be kept under review and, where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

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 always safe.

There was not always sufficient staff to ensure the safety of people. Risk assessment was not always current and reflective of risk to people and staff. The service was clean and fresh. Medicines were administered as prescribed and were stored appropriately. Staff were recruited appropriately.

Is the service effective?

Requires Improvement

The service was not always effective.

Care planning was not up to date and reflective of people's needs and wishes. Staff were not always trained effectively to deal with the needs of people.
People's consent was not always sought. People's health care was promoted through contact form health and social care professionals. People's nutritional needs were met.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff delivered care in a kindly manner. People's independence was not always promoted and people were not always involved in the running of the service. People's dignity was promoted.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care was not person centred. Staff were not deployed in a manner that met people's recognised needs and wishes. There was a complaints process in place.

Is the service well-led?

Inadequate

The service was not always well-led.

There was a quality assurance process in place, however this was ineffective and had not identified the areas of concern raised by

our inspection. The service lacked effective and consistent management. Staff were not supported. Records were not accurate and were not stored appropriately.

Heathcotes Chesterfield (Pennine House)

Detailed findings

Background to this 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 was planned to check 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 look at concerns we received about the service and to provide.

We inspected the service on 16, 24 and 29 August 2018. The inspection was unannounced and was conducted on 16 August by two inspectors and one expert by experience, on the 24 August by two inspectors and on the 29 August by one inspector. It was the first inspection of the service.

Prior to our inspection visit we reviewed information we held about the service. This included information received from local health and social care organisations and statutory notifications. A notification is information about important events which the provider is required to send us by law, these include allegations of abuse and serious injuries. We also contacted commissioners of the service and asked them for their views.

During our inspection visit we spoke with two people who lived at the service, five members of care staff and two representatives of the provider.

To help us assess how people's care needs were being met, we reviewed all or part of three people's care records including their risk assessments. We also looked at the medicines records of three people, three staff recruitment files, training records and a range of records relating to the running of the service, for example, audits and complaints. We carried out observations of care and support and looked at the interactions between staff and people who used the service.

Inadequate

Is the service safe?

Our findings

People's and staffs' safety was put at risk through lack of effective pre-admission assessments, this led to admissions of people whose needs staff struggled to meet. This was done at a time when there was no stable management in the service and the staff group was inexperienced in caring for people with complex needs. For example one person was admitted in the night. The staff were not informed they were being admitted and had not had the opportunity to assess how they service would accommodate and meet their needs or how their admission would impact on staffing levels or other people living in Pennine House.

We noted the staffing levels were not reviewed following this admission. On the night after they were admitted the rota showed one staff was on duty. We were told two staff were needed on duty at night. This was because some people smoked and had to be supported to do this outside the house. Another person was at risk of absconding, When this happened staff were unable to follow them because of the risk of leaving one staff member in the home. By not reviewing the staffing levels at night and ensuring the risks to people and staff were assessed and risk mitigated people and staff were put at risk.

Once admitted, some people did not have a review of their care, or have a risk assessment for up to six weeks. This left staff without direction on the risks to themselves, the person and other people living at the service. When risk assessments were in place they varied in the quality of the information provided to staff. For example staff had recognised risk to themselves and had put their own risk reduction actions in place. This varied between staff, depending on experience, the risk assessments had not been reviewed by management staff and the staffing group were without clear direction on how to keep people and themselves safe. This resulted in staff being at risk and while staff protected people they received injuries themselves.

Risk was not managed effectively. At the end of the day shift we saw several examples where the day staff were unable to leave as people and their colleagues were at risk of injury. Staff had no direction on what to do in these situations. Night staff were dependent on the good will of day staff staying over their hours. For example on Sunday night 28 August a member of day staff stayed on at the end of a long day shirt to support a colleague who had been injured and needed to go to hospital.

We asked for detail on how these risks were reviewed and there were no records of actions taken and staff were unable to tell us, beyond they got paid for their additional hours, what actions managers had taken to protect them and people. There was no increase to the night staffing levels.

One action taken by managers increased the risk to people. This was to prohibit a person from smoking. This was done without considering the risk that may arise from this action and their duty of care to keep people safe from avoidable harm.

Staff we spoke with were able to tell us what their of duty care to keep people safe was. However staff had not put this into practice and had not made safeguarding referrals where people's care needs were unmet and this resulted in continued risk to staff and people.

The provider failed to have an effective overview of the risks associated with people's care and treatment to promote their on-going safety.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

There was not enough staff to meet people's needs in a timely manner. The provider did not ensure there was consistency in staffing Pennine House. We were told the service needs two staff at night to keep people safe and to meet their needs. We noted from the rota supplied to us the staffing levels at night were inconsistent and did not meet this requirement. On the 27 and 28 May 2018 there was one staff on duty. On the 29, 30 and 31 May there were two staff on duty. On the 1, 2 and 3 June no night staff are shown on the rota and on 5 June it showed one staff on duty. This lack of consistency in staffing shows the provider could not be sure people and staff are kept safe from avoidable harm.

The provider did not ensure staff were deployed in a manner that kept them safe and was in line with European Working Time Directive. Staff regularly worked a 14 hour shift and then did not have the required 11 hour break between shifts. Staff were not allocated breaks in their 14 hour shift. We were told staff could take a break if they needed it, however, they were not assured of their rights to take a break and some staff were not confident in asking for a break. The rotas we reviewed did not show any staff breaks build in to the working day. Nor did they reflect the hours worked. To ascertain hours worked by staff we had to look at staffs' timesheets. These showed staff worked very long hours.

No risk assessments were carried out to ascertain if staff could provide effective care during these long shifts, particularly at the end of the shift. One staff member over a period of seven days worked six days with shifts averaging 14 and a quarter hours with no identified breaks in these shifts.

Another staff member worked continuously from 7 am on the 27 July until 8 pm on the 28 July 2018. This was a 37 hour shift without a break. On the 31 July they worked a 25 hour shift and on the 2 August they worked a 25 hour shift. There was no way of knowing how many hours were sleeping or waking. The time sheet indicated hours claimed. Staff we spoke with said sometimes they 'get their heads down.' Day staff told us they often cannot finish their shift on time as the night staff were unable to meet the needs of people. This lead to one staff member working 23 hours without a break on the 26 August 2018 as a staff member had been injured. Staff said they did not want to work such long hours but felt due to lack of managerial support they needed to support their colleagues.

The provider failed to ensure there were sufficient numbers of staff to care for people in a safe manner.

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

The people we spoke with said they were taking regular medicines. Few people were able to tell us precisely what medicines they were taking, however people were able to tell us they were offered their medicines that were prescribed as required. Some people were on as required (PRN) medicines and were able to assure us they received them as needed.

Accurate records of this were made in the medication administration records (MAR's). Following the completion of the medicine round the staff member double checked the MARs to ensure they were properly completed. Medicines were stored appropriately and there were systems in place to ensure unused medicines were returned to the pharmacy.

Staff who were responsible for the administration of people's medicines had taken part in appropriate training and had been assessed to ensure they were competent to administer medicines. However, on the first inspection visit we found there were no trained staff available to administer medicines at night. This was addressed by the time of the second visit.

Adequate steps had been taken to ensure people were protected from staff that may not be fit and safe to support them, as a safe recruitment process was in place. Each of the three staff files we viewed had the necessary information on the staff's identity, work history and security checks.

The service had good infection control procedures in place and we found Pennine House was clean and fresh and people using the service lived in a safe, clean, well maintained environment. Bedrooms were personalised to reflect their own interests and preferences.

Requires Improvement

Is the service effective?

Our findings

Care plans did not always reflect the needs and wishes of people. The service was not always able to understand and meet the needs of the people it cared for. This resulted in at least one person receiving poor care. For example one person staying in their room because staff did not know how to care for them. They left their room only to get food from the kitchen. Because of their conversations with their social worker showed their mental and emotional health had deteriorated since admission to Pennine House. Care plans were not always current and therefore did not give staff clear directions on how to meet the complex needs of people. This resulted in people's needs not been recognised and met.

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 the 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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards [DoLS]. We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

Most staff had a knowledge and understanding of MCA and DoLS. Information available showed that each person who used the service had had their capacity to make specific decisions assessed. Where people lacked mental capacity, appropriate applications had been made to the local authority for DoLS assessments to be considered for approval. However some people, who were deemed to have full capacity, made clear decisions that were not respected. For example a manager decided to curtail their access to cigarettes, making the last one 10 pm and their first one in the morning. This person told us cigarettes were very important to them and they did not agree to this curtailment. This impacted negatively on the person and resulted in them staying awake all night waiting for their morning cigarette. Their attempts to get cigarettes in that time resulted in an assault on staff. This lack of consultation was not in the best interests of the person or staff. The new manager was reviewing the situation.

Where a pre-admission assessment had been conducted the placement was successful. Staff told us they had spent a week getting to know a person prior to admission. They knew the person's wishes and needs and the transfer from hospital to residential care was successful.

Staff had received basic training. Most of staff were inexperienced and they told us they were not always confident in caring for all people. The current manager was aware of this and was reviewing care plans and training as a matter of urgency.

People had access to comfortable communal facilities, comprising of two large lounges and a dining area. However, while the environment was in good repair and condition, the garden was not secure as it was easy for people to get over the fence and abscond. This was under review and some garden equipment had been

re-positioned to ensure it wasn't used to assist people to climb over the fence.

Most bedrooms were personalised to reflect their own interests and preferences. This included people's bedrooms and we saw people had their personal possessions around them.

Staff we spoke with could not always ensure their care and support was delivered in line with legislation and nationally recognised evidence based guidance. They were not always aware of the need to promote people's rights under the Equality Act.

Steps were not consistently taken by the provider to ensure people were supported to have their varied and diverse needs identified and met. The provider could not be sure that people did not experience any discrimination.

The provider did not always ensure staff were trained to meet people's diverse needs. Some people living at Pennine House had complex needs. Staff had been not trained in how to respond to people's behaviours and to understand what they represented. This meant they could not offer care that was effective in meeting people's needs.

Staff were not supported and supervised in a manner that ensured they had the opportunity to discuss any problems or issues they may have in the work place. Staff, particularly when they were injured did not feel supported. There was no system in place to ensure staffs' welfare following an incident at work where they could have been inured physically and there was no emotional support for staff. Some staff were scared of people they cared for, there was no recognition of this or support put in place.

There were no staff appraisals therefore no personal development plans were in place for staff to receive feedback on their work. Some supervisions had been completed at irregular intervals. This was to allow staff the time to express their views, to reflect on their practice, their training needs and to discuss their professional development. We did not find evidence this had been followed through.

People's physical health was promoted. People had access to health and social care professionals. People were in good physical health. People had their mental health monitored and when there was a deterioration, appropriate referrals were made.

People were provided with good nutrition. People were happy with the quality of the food offered to them and were able to have their tastes catered for. The new manager was reviewing the menu planning with a view to offering more healthy choices. People had access to a range of snacks as well as more formal meals.

Requires Improvement

Is the service caring?

Our findings

We found staff interactions to be kind, and they showed they cared. Staff told us they were not always confident in caring for people and this resulted in some people been isolated in their room. Our observations supported this. One person told us the staff were kind and another said the staff were always trying to do their best. We saw staff interact with people

We saw staff were caring and kind and interactions were considerate and respectful. For example one staff member assisted a person to interact and talk with us. They did this with care and were careful not to respond for the person and to allow them time to consider the questions we asked.

The provider did not provide sufficient resources to ensure people's independence. People were taken out into the community at a time that suited staff and the service rather than when suited them. This meant people did not have sufficient say in how they wanted to spend their time.

There was no evidence people were effectively consulted on how they wanted to spend their time or how they wanted their social lives organised. People we spoke with told us they wanted to have more of a social life at night. We did not find evidence this was acknowledged or supported.

Staff told us that whilst they encouraged independence many people were not motivated to participate in daily living activities and were happy for staff to prepare their meals and do their laundry. Staff did not have sufficient directions on how to overcome this and to support people to become more independent.

Most staff were new but they were enthusiastic and able to share what knowledge they had of people and their daily routines. We saw that staff were caring and they supported people in a manner that promoted their dignity and privacy.

Where people had complex needs, and staff did not have clear directions on how to care for them they were left isolated in their rooms. Staff were unable to tell us how they were offered emotional support. Other people whose needs were less complex were offered emotional support.
People who did not have families or representatives had access to Advocacy services.

People and staff told us visitors were always welcomed to Pennine House at any time. When family members could not visit we saw staff took people to visit families.

Requires Improvement

Is the service responsive?

Our findings

The service was not always responsive to people's needs. Because of this care was not always person centred and staff deployment did not always suit the needs of people. The new manager was aware the care plans needed to be reviewed and had started this process.

Most of the people in Pennine House were young, this was not taken into account in the deployment of staff during the late evening or at night. The staffing levels reduced to two at 8pm. This meant none of the young people could have a social life in line with their age group in the community. Their additional support was provided in the morning or during the early part of the day which was not what they wanted. We noted one person had their one to one time was allocated to them while they slept in the morning. This was not responsive to their needs and wishes.

Another person frequently absconded at night. Again, their one to one support was rostered when they slept during the morning. How they wanted to spend their time was not clearly documented in their care plan. When this person absconded they were at risk. This risk may have been mitigated had their one to one time being allocated later in the day.

People who needed two staff to keep them safe in the community, were not always free to use this time as staff were not always available to accompany them. For example two people needed this support and both couldn't use their hours at the same time as the staffing levels did not facilitate this.

There was not always enough staff on duty to ensure people needs were responded to. A review of rotas and conversations with staff supported this. This meant people were not able to leave this house and attend external activities on a regular basis or have access to the community, as they needed either one to one or two to one care staff with them. There was a lack of planning and engagement around people's needs and wishes in relation to keeping they occupied and engaged.

There was no record of activities and activity planning. People were not always provided with accessible information to support their care at the service.

Some staff did not have the confidence and knowledge to provide care in a responsive person centred manner and because of this people were given minimum attention and had only basic needs such as their meals and laundry met. This resulted in people spending all their time in their bedrooms. The new manager was aware of this and had started to review their care and welfare.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

A complaints process was available and at the time of our inspection there were no outstanding complaints. However we noted one person had made their unhappiness about one issue clear this had not been regarded or investigated as a complaint.

No one was at end of life at the time of our inspection.

Inadequate

Is the service well-led?

Our findings

This was the first inspection of this service since it was opened in August 2017. The service is required to have a registered manager. 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. The service did not have a registered manager.

The service has numerous managers since the service opened. None of these had been registered with the Care Quality Commission. Another manager had been recently appointed they had been in post a short time. They appeared experienced and were aware of the issues in the service. They were currently being supported by a senior manager from another of the provider's services.

There was a high turnover of staff and staff felt unsupported and without guidance on how to keep people and themselves safe. Some staff had no experience of care and while they had basic training, because of lack of clear management direction they struggled to recognise and meet peoples' needs and wishes. Some staff were scared of some people and because of this people's needs were not always recognised and met. Staff were injured on a regular basis and there was not support system in place to ensure their welfare. The provider had not addressed these issues in a timely manner.

Staff worked long hours and there were no accurate records of this other than pay sheets. The rotas were not representative of hours worked by staff. The long hours of up to 37 in one shift were not reviewed and there was no way of knowing the impact of these hours on staff and the people they cared for. Staff were not supported in these long shifts by having dedicated breaks to ensure their wellbeing.

There was a quality assurance in place. These covered all aspects of the service including risk assessment and care planning. However, prior to the new manager starting, none of the issues raised in the report had been identified or addressed. For example, admitting people without knowing if the service could meet their needs or if the staffing levels are sufficient to meet people's needs. The risk to people and staff had not been addressed.

The provider did not have a tool for assessing the staffing levels needed to meet the needs and wishes of people. Instead we were told the staffing levels were determined by the funding process. By doing this alone the service was unable to demonstrate how they meet people's needs and wishes. The lack of consistent management meant the provider was unable to demonstrate how they deliver high quality service.

Records were not always stored in a confidential manner. We found a current member of staffs' file in an unlocked cupboard in the sitting room.

The lack of analysis of incidents meant there was a lack of adequate control measures put in place to reduce reoccurrence. This resulted in staff being at risk that may have been avoided with adequate reduction measures in place.

Staff had not been adequately supported and they did not feel listened to, we were told they did not have the confidence to approach senior staff as they found them intimidating.

There were no systems in place to review incidents with a view of identifying when risk reduction could be put in place. All incidents were recorded and reviewed but no action had been taken to reduce incidents, such as reviewing staffing levels and deploying staff at a time that matched people's waking hours.

The provider consistently failed to have effective oversight of the service and as a result, this lack of awareness and lack of oversight meant people in their care were not receiving the standard of care expected of a care home.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

The provider had process in place to work with other agencies. Social workers we spoke with supported this.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider did not ensure people received care that met their needs and wishes.

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 ensure there was sufficient numbers of appropriately trained staff to care for people.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not ensure the service had stable and effective management.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider did not ensure there was sufficient staff to care for people. Staff worked very long hours without a break.