Swanton Care & Community Limited

# Heath Farm House Care Centre

## 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
Heath Farm House Care Centre is a care home, providing personal and nursing care for up to 10 people living with complex mental health conditions and or learning disabilities. At the time of the inspection, seven people were receiving care. The service has been set up collaboratively with the local authority to reduce the risk of delayed discharge from hospital or for those who require hospital avoidance due to deterioration in their mental health and wellbeing. The service provides short term, residential support.

People's experience of using this service and what we found
We identified significant concerns in relation to the safe running of the service, which raised questions about the standards of care being provided. There was a lack of managerial and provider level oversight, which had resulted in multiple incidents including safeguarding concerns, which had not been handled in line with their own policies and procedures, to maintain people's safety and wellbeing.

People told us they sometimes felt unsafe living at the service, and would spend time in their bedrooms, rather than in communal areas to alleviate those feelings. We identified concerns in relation to infection, prevention and control standards at the service, which was of concern as the service was inspected during a national lockdown.

The provider had not implemented enough changes to practice and approach to ensure that people received good standards of care and support and was reinforced by repeated and new breaches of regulation being identified at this inspection.

We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, 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 providing support to people with a learning disability and/or autistic people.

The service was not able to demonstrate how they were meeting some of the underpinning principles of Right support, right care, right culture. At the last inspection, it was identified that the service did not fully meet the requirements to meet the needs of people with autism and learning disabilities in line with best practice guidance.

Following the last inspection, the decision was made to close the service and support people to move to more suitable alternative accommodation. However, in consultation with the local authority, the decision was made to alter the purpose of the service. As an outcome, the service was being refurbished at the time of our inspection visit, but the size, layout and suitability had not changed to be more in line with right support, right care, right culture as set out in the guidance. Whilst most people living at the service had complex mental health support needs, there remained people living at the service with autism and learning disabilities.

Right support:
• Model of care and setting maximises people's choice, control and independence

Right care:
• Care is person-centred and promotes people's dignity, privacy and human rights

Right culture:
• Ethos, values, attitudes and behaviours of leaders and care staff ensure people using services lead confident, inclusive and empowered lives

Rating at last inspection
The service was rated requires improvement with breaches at the last inspection, completed 17 October 2019, published 09 January 2020.

The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection enough improvement had not been sustained and the provider was still in breach of regulations.

Why we inspected
We received concerns in relation to management changes, staffing levels and training, and received anonymous whistleblowing concerns. There had also been a serious incident that had happened a few days prior to our site visit. 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.

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 coronavirus and other infection outbreaks effectively.

Enforcement
We have identified repeated breaches of regulation in relation to provision of safe care and treatment, trained and skilled staffing and good governance arrangements. We have also identified new breaches in relation to keeping people safe from risk of harm and abuse, and in relation to notifying CQC of incidents that have occurred at the service, during this inspection.

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 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.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

**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.

# Heath Farm House Care Centre

**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.

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
Consisted of two inspectors.

Service and service type
Heath Farm House Care Centre is a care home that provides nursing and personal care.

The service had a manager in post, but they were not registered with the Care Quality Commission. This means that the provider is legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
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.

We reviewed information we had received about the service since the last inspection. This included details about incidents the provider must notify us about. We liaised with third party stakeholders, including local social care services before the inspection site visit. We used all this information to plan our inspection.

During the inspection
We spoke with the regional manager and new manager, a contractor and observed care and support provided in communal areas. We looked at three people's care and support records and four people's medicine records, as well as a sample of medicines, and observed some of the medicines round in progress. We looked at staff files as well as records relating to the management of the service, recruitment, policies, training and systems for monitoring quality. We requested provision of additional information that was sent to us after the inspection visit.

After the inspection
We completed telephone interviews with two people living at the service and two members of care staff. We liaised with the local health and social care services. We also requested provision of further information and clarification from the regional manager and new manager.

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.

At our last inspection we found the provider had not appropriately recorded, assessed or mitigated risks. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had not been made at this inspection and the provider remained in breach of regulation 12.

Assessing risk, safety monitoring and management

- From reviewing documents, and speaking with staff, there was no clear direction for staff to follow in relation to the timing and frequency of welfare checks where a person's condition had deteriorated. We also identified multiple episodes of staff needing to use their own car keys or coins to be able to open people's ensuite bathroom doors when required, as there was no master key. This meant staff could not always respond in a timely way to incidents of risk. Following our inspection, we received assurances from the provider that additional training with staff had been provided to ensure they were aware that they had an object on their key rings to assist them to open the ensuite doors where required.
- Monthly health and safety audits did not include checks of window restrictors or ligature risks. When requested, there were no risk assessments in place regarding contractor's tools and equipment being accessible to people using the service.
- The service was undergoing renovations, but the layout and design of the building remained the same as at the last inspection. Therefore, continuing not to fully meet the right support, right care, right culture principles. For example, the service was a large home, bigger than most domestic style properties. It was registered for the support of up to 10 people.
- We reviewed risk management plans in place for people. We identified a significant change in risk scorings between assessed risks before and after measures and mitigation had been implemented. However, it was unclear how this level of risk reduction was assessed where people were newly admitted to the service, with unknown or unfamiliar risks.
- Four people required staff to support with weight monitoring linked to health conditions and risks. We identified a significant discrepancy with weights taken which had not been picked up by the service's own checks and systems in place. For another person, their care records recommended weighing them a minimum of once every three months. Their records showed they had not been weighed in 10 months.
- We observed the fire evacuation drill at the service during the inspection. No staff member took the lead, staff counted people in the car park as there was no name or room list available. No one took the grab bag outside to ensure staff had access to relevant information and resources. The service's training matrix identified there were no designated staff with up to date fire marshal training in place.

Risks relating to the health and welfare of people were not fully assessed and managed. This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection we found the provider had not assured themselves they had enough staff suitable employed and deployed to meet people's needs. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had not been made at this inspection and the provider remained in breach of regulation 18.

Staffing and recruitment

● From reviewing people's care records, we identified people requiring 2:1 support, for example in the management of risks relating to people making allegations against staff. However, there were only two staff on shift at night-time. When we spoke with staff, they identified this as an area of concern. They also identified this as a potential risk during the day as staffing numbers tended to go down to two. This was due to staff supporting people to access community activities and appointments.

● From records, and speaking with staff, many people required 1:1 assistance to evacuate the building in an emergency, such as in the event of a fire. When there were only two staff on shift at night, this would not enable that level of support to be consistently provided, while safely leaving the building.

● The new manager had been in post approximately four weeks at the time of the inspection, and from reviewing records was involved with the day to day running of the service, including the provision of staff supervision and completion of audits. However, from reviewing their training records, they had not completed any of the provider's mandatory training courses, with were all showing as in progress.

● We identified concerns and significant shortfalls with overall levels of staff training compliance. We also identified a lack of specialist, role specific training for staff to access. We were therefore not assured staff had the necessary skills and competencies to safely meet people's needs.

Risks remained, relating to staffing levels and skill mix. This was a continued breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection, we made a recommendation the provider ensured staff were confident in current safeguarding procedures and assured themselves incidents and allegations of abuse are reported in line with regulations.

Enough improvement had not been made at this inspection and the provider was now in breach of regulation.

Systems and processes to safeguard people from the risk of abuse

● People gave examples of incidents that had happened and told us they did not always feel safe living at the service, and at times would return to their bedrooms rather than remaining in communal areas.

● From reviewing incident and accident reports, we identified examples of people reporting concerns such as being threatened by other people living at the service. Staff had recorded these concerns, but not reported them to the local authority safeguarding team.

● We identified examples of where people had reported allegations to staff, such as the theft of their bank cards. Records showed staff had investigated these concerns internally but had not reported the allegations to the local authority safeguarding team or the police, in line with the provider's own policies and procedures.

● We were not assured that people were being protected from risk of harm and abuse or that staff had the necessary skills and training. Not all staff, including the new manager had up to date safeguarding training in place.

Measures were not in place to protect people from risk of harm and abuse. This was 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.

Using medicines safely

● From reviewing the service's training matrix, we identified that staff completion rates for medicine management training was low.

● The medicines trolley was kept in one room, and from guidance reviewed, staff were meant to take medicines out of the room on a tray. When we arrived on inspection a staff member was holding medicines under their arm.

● The agreed method of carrying the medicines on a tray was not in place, and not followed again when we were present for the lunchtime round. This was raised with the regional manager.

● We observed staff to experience multiple interruptions including answering the telephone, while completing the medicine round. We were therefore concerned at the time lapse between potting up the medicines, giving the person their medicines and then filling out their records, and the increased risk of errors. For example, staff had missed a person's prescribed medicine for 27 consecutive nights.

● Where people refused medicines, the guidance in their care plans told staff to 'monitor for ill effects.' It did not provide any guidance of what these ill effects may look like, or timescales before staff needed to contact the GP or a health care professional for advice. This was of concern for a person diagnosed with diabetes, but we also recognized that many of the people living at the service had complex medicine regimes, and repeated refusal of medicines would have a direct impact on their mental health and well-being.

Risks relating to the safe administration of people's medicines were not in place, and guidance was not consistently being followed. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection

● We were not assured that the provider was preventing visitors from catching and spreading infections: We were not asked to complete a health questionnaire on arrival. There was no hand sanitizer or hand washing facilities in the reception area, and no wipes to clean the thermometer between uses. The service did have arrangements in place for completion of testing for visitors.

● We were not assured that the provider was meeting shielding and social distancing rules: There was a lack of ventilation or recognition as to why this was required.

● We were not assured that the provider was admitting people safely to the service: People were not expected to complete a period of isolation on admission, and this was not something being discussed and agreed prior to admissions to support people to prepare.

● We were not assured that the provider was using PPE effectively and safely: There were no designated donning and doffing areas and staff were only observed to be wearing masks as standard, even when completing tasks such as giving people their medicines. Staff did not wear a uniform and were not working bare below elbow in line with best practice. The provider could not be confident that staff were regularly laundering their clothes to prevent the spread of infection.

● We were not assured that the provider was promoting safety through the layout and hygiene practices of the premises: Consideration had not been fully given to how shielding and social distancing should be achieved and maintained at the service. For example, seating was not spaced out, corridors were narrow,

and many of the people living at the service struggled with maintaining social distance. The provider had not taken these factors into consideration when assessing risk.
● We were not assured that the provider's infection prevention and control policy was up to date: Risk assessments corresponding to the policy had not been updated to reflect use of COVID-19 testing, there was no reference to arrangements for new admissions including use of isolation. Following completion of the inspection site, visit the provider sent inspectors a more up to date version of their COVID-19 risk assessment.
● We were not assured that the provider was making sure infection outbreaks could be effectively prevented or managed: The service had had no outbreaks; however, we were concerned to identify that not all staff had completed IPC training. There was an overall lack of robust systems and measures to ensure prevention of an outbreak from happening. People relied on the staff to ensure safety measures were in place.

Measures were not in place to prevent the risk of the spread of infection. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the inspection visit, the service has provided CQC with an up to date version of their COVID-19 risk assessment.

● We were assured that the provider was accessing testing for people using the service and staff. Staff, people and visitors including contractors told us they were completing regular testing.

Learning lessons when things go wrong
● There was a lack of lessons learnt being recorded on the accident and incident forms, that were signed off by the regional manager. We were not assured that relevant analysis of themes and trends was being completed, due to the level of risks and concerns we found when reviewing these documents.
● We were concerned that information being raised by people was not being recognized or acted on to prevent risk of reoccurrence.
● Where safeguarding incidents had occurred, the service's own incident forms identified times where staff had not followed their own policies and procedures.
● From reviewing recent incidents that had happened, we were not assured that measures had been implemented to reduce the risk of reoccurrence, or that this information was being disseminated to staff.

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.

At our last inspection we found there was not an effective system of governance and oversight to drive improvements required. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had not been made at this inspection and the provider remained in breach of regulation 17.

Continuous learning and improving care; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- We identified risks and concerns that were not being picked up from the checks and audits in place at the service. We identified a consistent lack of provider level oversight, recognising that in the absence of a registered manager, the provider would be legally accountable for the safe running of the service.
- The service's policies and procedures, including their business continuity plan required updating to reflect correct contact information, but also to ensure staff were working in line with current government guidance.
- The service provided us with their own list of accidents and incidents for each week in January and February 2021. These numbers did not correspond with the number of incidents reviewed for the same time period when looking at individual incident forms. Again, this did not offer assurance of the level of provider and managerial oversight of the service.
- Monthly health and safety audits were being completed by the new manager (who had not finished completing any of the provider's training). There were no recorded checks of the outside of the service, yet we observed there were loose bricks, multiple ligature points, and accessible risk items such as drinks cans which could be used as a method for self-harming. We also identified audit action points to be rolling over from one month to the next.
- Daily audits did not have the time of completion listed, although from speaking with staff, they told us these were usually completed during the night shift. The documents did not include any details of rooms or bathrooms checked. The form did not contain current information and risk management regarding COVID-19, to demonstrate amendments being made as guidance changed.
- The service had potential to offer a person-centred, holistic approach. However, still did not fully meet the right support, right care, right culture principles. Staff did not have access to specialist training and overall training compliance levels were poor.
- We needed to request governance information more than once and identified that the managers were unable to compile an overview document for them to review. This raised questions regarding the regional and new manager's abilities to have safe oversight of the running of the service, or that analysis was being

completed to review for themes and trends.
● The service had had changes in managers, this impacted on the embedding of changes, and consistencies in approach for staff to implement to drive improvement at the service.

The service continued to have poor governance arrangements in place to drive improvement at the service. This was a continued breach of regulation 17 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements
● Some concerns had been identified in relation to the service provider consistently submitting notifications to CQC. As a result, additional written guidance had been sent to the regional manager to support with this process, prior to the inspection. During the inspection the regional manager provided verbal assurances that they were clear all notifiable incidents were being reported to CQC.
● We completed a review of incidents that had occurred between 05 December 2020 and 31 January 2021. Of those many were assessed to meet the notification threshold but had not been submitted to CQC.
● We were not assured that the service provider had oversight of the handling of these incidents or ensured transparency in sharing information of where things had gone wrong, to stakeholders in line with the duty of candour, and regulatory responsibilities.
● The service provided us with an updated version of their statement of purpose. However, we identified that this listed the incorrect regulated activity being provided.

The provider was not maintaining their regulatory responsibilities to notify CQC of events when needed, resulting in a breach of Regulation 18 of CQC Registration regulations (2009).

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others
● People told us they felt well informed about the pandemic, and arrangements in place during the national lockdown.
● People told us they were supported to access medical appointments, and to attend review meetings.
● Staff told us they received regular support and supervision from the new manager and had found their approach to be nurturing and supportive.

This section is primarily information for the provider

# Enforcement actions

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

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 18 Registration Regulations 2009 Notifications of other incidents<br><br>The care provider had not ensured incidents and safeguarding concerns had been notified to CQC.<br><br>Regulation 18 Registration Regulations 2009 (1) (2) (e) (f) |

**The enforcement action we took:**

A condition was imposed on the provider's registration at this location.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>The care provider did not always ensure that people and the care environment were consistently kept safe. Risks to people were not always well managed, including with medicines management<br><br>Regulation 12 (1) (2) (a) (b) (g) |

**The enforcement action we took:**

A condition was imposed on the provider's registration at this location.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>The care provider was not preventing the risk and spread of infection, including COVID-19.<br><br>Regulation 12 (1) (2) (h) |

**The enforcement action we took:**

Warning notice

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or | Regulation 13 HSCA RA Regulations 2014 |

| | |
|---|---|
| personal care | Safeguarding service users from abuse and improper treatment<br><br>The care provider did not ensure people were always protected from risks of harm and abuse.<br><br>Regulation 13 (1) (2) (3) |

**The enforcement action we took:**

A condition was imposed on the provider's registration at this location.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>The care provider did not have good governance processes and procedures in place. Audits and quality checks were not identifying risks and concerns found during the inspection, or mitigating and addressing and areas of poor practice.<br><br>Regulation 17 (1) (2) (a) (b) |

**The enforcement action we took:**

A condition was imposed on the provider's registration at this location.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 18 HSCA RA Regulations 2014 Staffing<br><br>The care provider did not ensure there were sufficient levels of staff on each shift to meet people's care and support needs and assessed risks.<br><br>Regulation 18 (1) |

**The enforcement action we took:**

A condition was imposed on the provider's location.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 18 HSCA RA Regulations 2014 Staffing<br><br>The care provider was not ensuring staff had the necessary role specific training, skills, competence and knowledge to meet people's care and support needs and risks.<br><br>Regulation 18 (1) (2) (a) (b) |

**The enforcement action we took:**

Warning notice