Heathcotes Care Limited

Heathcotes Chesterfield (Loundsley House)

Inspection report

Loundsley House
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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Heathcotes Chesterfield (Loundsley House) is a residential care home for people with learning disabilities, and/or autism and complex mental health needs. The care is provided in a purpose-built home for 8 people. There were 6 people living at the home at the time of our inspection.

People's experience of using this service and what we found
The outcomes for people using the service didn't reflect the principles and values of Registering the Right Support. The least restrictive options were not always used to protect people from harm. Medicines management was not always picking up potential risks to people's wellbeing. Risk was not always managed to ensure staff received up to date guidance in supporting people. When incidents occurred, they were not fully reviewed to learn from them and reduce the risk of recurrence.

Staff were not following the government guidance to manage infection control during the Covid 19 pandemic. The provider had not given sufficient guidance and support to ensure this was adhered to. Additional staffing was provided by staff from other locations and the risk of cross contamination across homes had not been sufficiently assessed and addressed.

The systems in place to have oversight of staffing, medicines management and risk to people were not thorough enough to manage and improve the service. Some staff and families felt they could give feedback openly; but others felt the turnover of leadership at the home impacted on maintaining improvements.

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

Rating at last inspection
The rating at the last inspection was inadequate (published 19 February 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 not enough improvement had been made and the provider was still in breach of regulations.

Why we inspected
We received concerns in relation to the management of medicines, infection control and management in the home. We reviewed the information we held about the service. We completed a risk assessment relating to the Covid19 pandemic that was ongoing at the time this inspection was completed. As a result, we undertook a focused inspection to review the key questions of safe and well-led only. Ratings from previous comprehensive inspections for the other key questions were used in calculating the overall rating at this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for

Heathcotes Chesterfield (Loundsley House) on our website at www.cqc.org.uk.

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

We have identified continued breaches in relation to risk management, safeguarding people from harm, staffing levels and support, and good governance at 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
The overall rating for this service is 'Inadequate' and the service remains in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

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

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it. And it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well led findings below.

Heathcotes Chesterfield (Loundsley House)

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
The inspection visit was completed by two inspectors and was supported by two assistant inspectors who made additional telephone calls.

Service and service type
Heathcotes Chesterfield (Loundsley 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.

The service should have a manager registered with the Care Quality Commission, but there was not one in post since August 2019. The registered manager and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We used information we held about the service which included notifications that they sent us to plan this inspection. We spoke with commissioners of the service and some professionals who support people living in the home.

During the inspection
We informed the provider on the morning of the inspection of the structure of the inspection; we planned to limit time in the home to reduce the risk of infection transmission under current Covid 19 restrictions.

We spoke briefly with some people who lived at the home and observed some staff support and interaction with people in communal areas during the inspection visit. We spoke with three people's relatives by telephone about their experience of the care provided. We also spoke with twelve members of staff by telephone.

We reviewed a range of records. These included care records and incident forms for all six people and three people's medication records. We looked at two staff records in relation to recruitment and supervision. A variety of records relating to the management of the service, including audits, were reviewed.

After the inspection
We completed a feedback meeting after the inspection and agreed that the provider would send additional evidence within three days to validate evidence found. We reviewed this alongside our other evidence to complete the 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 the last inspection this key question was rated as Inadequate. At this inspection this key question has remained the same. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

At our last inspection the provider had failed to robustly assess the risks relating to the health safety and welfare of people. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

• Risks to people's health and wellbeing were not sufficiently assessed, monitored and mitigated to protect them from harm.
• Some people had previous health conditions or injuries which had no guidance in their care plans for staff to follow. For example, in a meeting in April 2020 a discussion was recorded relating a health condition to one person's behaviour and alerting staff to support this. This was not put into a care plan and when there was a recurrence of this condition in June 2020 staff did not have enough oversight to respond promptly.
• After a period of being unwell another person had daily monitoring implemented to ensure they drank enough fluids. However, there was not enough oversight of this which meant the person drank variable amounts with insufficient quantities on some days to keep them well.
• Some people were supported to manage behaviours which could harm themselves or others. The plans in place did not always clearly identify triggers, actions to take and what staff should do if the behaviour was prolonged or repeated in a short period of time.
• There was not always a clear response to incidents or concerns to reduce the risk of repetition. For example, one person had a skin injury which required treatment. Their care plan was not reviewed or updated to ensure staff understood what action to take in future to ensure the person had timely treatment to any injury.

The systems in place were not robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• A multi-disciplinary consistent approach had been implemented to support other people and the provider shared feedback with us to demonstrate this was effective in reducing the number of behaviours which could harm.

Preventing and controlling infection

At our last inspection the provider had failed to robustly assess the risks relating to the health safety and welfare of people. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

• Infection control practices were placing people at risk of being exposed to infections. This included known risks associated with the current Covid-19 pandemic.
• During the inspection visit we witnessed staff were not wearing personal protective equipment (PPE) in line with national government guidance to protect themselves and people living in the home.
• Some staff did not demonstrate an understanding of the guidance or their responsibilities to adhere to it. For example, one member of staff told us they didn't wear face masks because people living at the home didn't like them. Another member of staff told us there was limited risk as people living at the home didn't socialise out of the home much. This showed us they didn't understand the risk of transmission from themselves to others.
• Staff from other homes often provided support in this home due to staffing shortages. The provider had not managed the increased risk of cross – contamination of infection that this posed.
• When we spoke with family members, they told us staff had not worn PPE when they visited or met their relatives outside.
• There was some equipment and rubbish in the property and garden which increased the risks posed to people living in the environment.

The provider had not ensured adherence to government guidance to manage infections during the Covid 19 pandemic nor checked the environment was suitably clean and tidy. This placed people at increased risk of harm. This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

At our last inspection the provider had failed to provide enough, suitably qualified and experienced staff. This was a breach of regulation 18(1) (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 18(1)

• At our previous two inspections we found staff worked excessive hours due to shortages of staff. At this evidence we found this was still the case.
• Some staff told us certain other staff worked long hours and back to back shifts without a break. We could not see evidence of this on staff rotas but we did find some examples when we cross referenced other records such as incident reporting and medicines administration records. When we raised this with managers, the feedback was it was staff choice to work the hours they did. They did not acknowledge the potential increased risk to people's safety if staff had worked up to 90 hours consecutively in a week.
• Some staff also raised concerns with us that a lot of staff were supporting from other homes who didn't know people well. One member of staff told us, "There aren't enough experienced staff. There are enough bodies here, but that's all they are."
• We reviewed staff rotas for the previous three months and found up to twenty different staff had supported from different homes. However when we reviewed other records, we found additional names who were not

on the rotas.
• We also found staff moved across services during a shift. One member of staff said, "We used to have enough staff at night but this has now reduced and we often we have to support next door which takes us down". We saw evidence of this in people's records when staff had attended this home from the one next door.
• When staff were regular and experienced, we saw personalised kind interaction with people. Families also spoke positively about certain named staff who they trusted. However, some family members also raised concerns about the turnover of staff and managers and the impact this had on the people living at the home, some of whom had limited verbal communication and relied on staff knowing them well to understand their needs.
• When we spoke with managers about staffing at the home, they explained that they were continuing to recruit new staff but some did not stay when they were in the job. They said they were reviewing their recruitment process to ensure potential candidates had a better understanding at interview.

This was a continued breach of regulation 18(1) (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• The provider had adapted their recruitment procedure in line with government guidance under the current situation with Covid 19.
• There were systems in place to 'buddy' new staff who had not yet received criminal checks while these were in progress.
• When there was a potential increased risk due to a new member of staff's previous background there was sometimes a delay in completing a risk assessment until documentation was received.

We recommend the provider completes risk assessments for new staff as soon as an increased risk is disclosed. This should be reviewed and amended at regular intervals including when documentation is received.

Systems and processes to safeguard people from the risk of abuse

At our last inspection the provider had not ensured that systems were safeguarding people and reducing the risk of harm. 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.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 13

• At our last inspection we raised concerns about insufficient oversight of physical restraint to ensure it was not overly restricting people in line with their human rights. At this inspection we found this was still not adequate, particularly in relation to administration of certain medicines which could chemically restrain people and the physical environment which could restrict certain people's liberty to move freely.
• There had been incidents of harm to people which the provider was not able to fully explain. The review of these incidents and the action taken to protect people from future harm were not thorough enough.
• Staff could explain to us about safeguarding and what action they would take if they were concerned about people's welfare. However, one conversation demonstrated this understanding was not necessarily embedded. We raised these with managers and were assured they would be reviewed.

The systems in place to fully investigate any potential infringements on peoples rights or to review potential incidents of harm were not sufficient to protect people from potential harm. This was a continued 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
• Medicines were not always managed to reduce the risks associated with them
• Some people were prescribed medicines to take when needed or PRN. There was not always clear guidance in place for staff to understand when they should be given. We spoke with the member of staff administering medicines on the day of inspection who was unable explain when they would give certain PRN medicines.
• One person had PRN medicines prescribed to assist them to calm when they were behaving in a way which could cause themselves or others harm. There were occasions when staff administered two of these medicines together. There was no guidance in place to state in what circumstances they should be given together despite the fact they would have a significant effect on the person. There was no evidence that physical causes of discomfort or pain had been considered before administration.
• Another PRN medicine was needed to help manage bowel movements. There was no guidance in place for staff to know when this should be given and at times staff had not checked other records to assess whether this was needed.
• There were errors in recording medicines. Another person had been administered PRN medicine on three occasions and only one was recorded on the correct date when cross referenced with incident reports. Doses of medicine given were not always recorded despite the prescription being for a variable amount. These errors in recording increase the risk of potential harm to the person in taking too much medicine.

The provider had not ensured that medicines were aligned to care plans and guidance given to staff to know when to administer and correctly record this. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as Inadequate. At this inspection this key question has remained the same. 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.

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

At our last inspection the provider had failed effectively implement systems and processes to manage risks to people living at the home. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17

• During the Covid 19 pandemic we held virtual meetings with the managers for this home on two occasions including during our interim support framework meetings. We were told all staff were complying with infection control and PPE government guidance for care homes designed to protect people and reduce the spread of the infection. We also received provider level assurances. When we inspected this home, we found this was not the case and staff were not following guidance and some had limited understanding of the reasons for it.
• Retention of staff and being able to provide a full team had been a recurring issue at this home over the past two inspections. During our meetings we were given assurances about staffing. We spoke about using staff from different homes or agency staff to cover vacancies and the increased risk of spreading infection. During the inspection we found staff from other homes were regularly providing support at this home and there were no systems in place to try to reduce the risk of cross contamination.
• At the last two inspections we were concerned about staff working excessive hours and we were assured through the provider action plan this would be closely monitored and welfare support offered. When we tried to monitor the number of hours staff had worked and the number of staff working at the home from other homes we found the rotas we were provided with were unreliable. This lack of accurate recording made it difficult to measure what the exact staffing situation was; however, staff we spoke with and families confirmed there were often staff present who were new or unfamiliar to people.
• Systems in place to monitor and reduce risk to people, reduce it and guide staff were not always effective in addressing the issues and impact on people. For example, one person had received PRN medicines for a specific condition but when we reviewed administration records, we found it had been given twice for 'agitation'. On one occasion it had also been administered without the required 4 to 6 hour gap increasing the risk of harm to the person. This had not been addressed through medicines audits.
• Similarly, a provider audit completed by another regional manager found another person had refused a

prescribed toothpaste and stated this refusal needed to be recorded. Consideration of why this was refused or the impact on the person in line with previous ill health was not completed.

Systems in place to monitor the service provided and ensure good outcomes for people were not always effective in doing so. The provider took some action after the inspection to manage some risks identified; for example, they improved the environment and altered some of the incident analysis. However, this remained an ongoing breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At our last inspection we issued a warning notice against regulation 17 and at this inspection we found there was not enough improvement made to meet this notice.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

• Some staff were confident in expressing their opinion and felt included in developing the service. Other staff told us they were not and felt the turnover in managers meant improvements were difficult to sustain. The manager who was present at the December inspection was no longer there, another manager had been in post and left since and leadership was now being provided from the regional manager and members of the quality team. They were also providing leadership to the home next door.

• Some staff felt the culture of the home was not open and they would be unwilling to raise concerns. The provider's policy on whistleblowing encourages staff to raise concerns but does state that disciplinary action may be taken if they raise them externally (unless they are exceptionally serious). This is not in line with CQC guidance which states 'an open culture allows staff to feel supported to raise concerns, both inside and outside of the service, without fear of recrimination.' Therefore, the culture may not be conducive to transparent feedback.

• Families confirmed the change in managers also made it difficult to sustain relationships. Some families applauded the efforts the home made to keep them in touch during the pandemic, including newsletters and visiting in the garden or outside. Others felt communication could be improved and they didn't always receive consistent information.

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; Working in partnership with others

• The provider had submitted statutory notifications as required. This is information about events occurring at the service, which the service is legally required to notify CQC about.

• Other professionals reported they were also informed of specific incidents and received regular monthly updates as agreed.

• During a partnership meeting it was recognised the difficulty in maintaining partnership working during the current restrictions under the pandemic. The managers of the home agreed to take additional action to ensure information was shared in a timely manner.

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 18 HSCA RA Regulations 2014 Staffing There were not always sufficient, trained and experienced staff available to support people safely.