Heathcotes Care Limited

Heathcotes (Arnold)

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service responsive?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

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

About the service
Heathcotes (Arnold) is a residential care home registered to provide personal and nursing care to up to ten people. The service provides support to people who have mental health support needs, learning disabilities and/or autistic people. At the time of our inspection there were five people using the service.

People's experience of using this service and what we found

Right Support
People lived in a property in which some fire doors were defective. This created a potentially increased risk of harm in the event of a fire. The provider told us they would rectify those issues. Waste management was not safe. External waste bins were overflowing and had attracted rodents. Parts of a person's individual living area required repair and refurbishment and floor coverings in some communal parts of the building required replacement. Staff did not always wear protective face masks and, when they did wear them, did not always wear them appropriately. Some relatives told us they felt the service could involve families more than they currently did. The service worked with people to plan for when they experienced periods of distress so that their freedoms were restricted only if there was no alternative. Staff did everything they could to avoid restraining people. The service recorded when staff restrained people, and staff learned from those incidents and how they might be avoided or reduced. People had a choice about their living environment and were able to personalise their rooms.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

Right Care
People had appropriate care plans and risk assessments in place and staff understood how to support people. The inside of the care home was generally hygienic and homely. People were supported by enough staff to meet their care needs. People's prescribed medicines were managed appropriately. Staff understood how to protect people from the risk of abuse and how to report any concerns. People received kind and compassionate care. Staff protected and respected people's privacy and dignity. They understood and responded to their individual needs. People could communicate with staff and understand information given to them because staff supported them consistently and understood their individual communication needs. Staff and people cooperated to assess risks people might face. Where appropriate, staff encouraged

and enabled people to take positive risks.

Right Culture
People were supported to maintain contact with their relatives and were encouraged to engage in community-based activities. People told us they knew how to complain if they were unhappy about anything at the care home. Staff told us they felt supported by the registered manager and told us they believed improvements in the service were being made. Staff placed people's wishes, needs and rights at the heart of everything they did. Staff knew and understood people well and were responsive, supporting their aspirations to live a quality life of their choosing.

We have made a recommendation about the management of premises checks and maintenance works at the premises.

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

Rating at last inspection
The last rating for this service was Requires Improvement (published 18 December 2019) and there was a breach of regulation. At this inspection we found improvements had been made and the provider was no longer in breach of regulation 9 (Person-centred care). However, the provider was found to be in breach of regulation 15 (Premises).

Why we inspected
The inspection was prompted in part due to concerns received about the support provided for people who were expressing distress or agitation; and to check the staffing levels at the care home. A decision was made for us to inspect and examine those risks. As a result, we undertook a focused inspection to review the key questions of Safe, Responsive, and Well-led only.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service remains Requires Improvement based on the findings of this inspection.

We have found evidence that the provider needs to make improvements. Please see the Safe section of this full report.

The provider has subsequently told us they intend to take action to mitigate the risks we identified during the inspection, by carrying out identified maintenance and refurbishment works to the property.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Heathcotes (Arnold) 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 will take further action if needed.

We have identified breaches of regulation in relation to the fire safety arrangements, maintenance processes, and the management of household waste at this inspection.

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

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service responsive?

Good

The service was responsive.

Details are in our responsive findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Heathcotes (Arnold)

Detailed findings

Background to this inspection

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

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

Inspection team
The inspection was carried out by one inspector.

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

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

At the time of our inspection there was a registered manager in post.

Notice of inspection
We visited the care home on 3, 4 and 10 October 2022. All inspection site visits were unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service.

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

During the inspection
We observed staff interactions with the five people who used the service. People were able to communicate verbally, but we also observed their body language during their interactions with care staff to further help us understand their experience of the care they received.

We used the Quality of Life Tool which is designed to support the corroboration of all sources of evidence gathered during inspection. We spoke with 11 members of staff including care staff, senior carers, the registered manager, and regional manager. We reviewed a range of records. This included three people's care records and a sample of medication records. We looked at three staff files in relation to recruitment and staff supervision.

We obtained clarification from the provider to validate evidence found. A variety of records relating to the management of the service, including policies and procedures, were reviewed. We looked at training data and quality assurance records. We received feedback from the relatives of one of the people who lives at the care home. We also received feedback, by phone or email, from eight staff.

Requires Improvement

Is the service safe?

Our findings

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

At our last inspection we rated this key question Requires Improvement. At this inspection the rating has remained Requires Improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management

- People were not always protected by the provider's fire safety arrangements. Two fire doors were damaged and could not be easily closed; and another fire door was routinely wedged open. This increased the risk that people might be harmed in the event of a fire.
- The provider's waste management arrangements were not safe. External waste bins were open, overflowing, and rodents were observed inside and around the bins. This was raised with the regional manager who subsequently informed us the provider would replace the bins, create better bin store facilities at the property, and implement a more effective rodent control regime.
- A person's rooms were not in a good state of repair which meant they could not be effectively cleaned. Damage was observed to walls in the person's bedroom and bathroom areas. This was raised with the registered manager who told us the damage was caused when the person became anxious and upset. They told us they were waiting for the rooms to be refurbished and re-decorated by the provider's maintenance team. However, this meant the person's individual living environment was poor at the time of the inspection which increased the potential for harm.
- People were not always protected from the potential accidental or intentional harm. Cleaning products were stored in lockable cupboards in the kitchen and bathroom. However, both cupboards were found to be unlocked. The inspector discussed this with the care staff who told us the cupboards were supposed to be kept locked to protect people from accessing items which might harm them.
- Some communal floor coverings on the stairs, landings and in some corridors were worn, stained and dirty. This was raised with the registered manager who told us those carpets would be replaced as part of the refurbishment plan for the property. However, this meant parts of people's living environment were poor at the time of the inspection. The failure to keep those areas clean and well maintained increased the potential for harm.

The provider failed to ensure the premises were properly maintained. This placed people at increased risk of harm. This was a breach of regulation 15 (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The provider assessed people's individual risks. Those risk assessments were used in the development of people's individual care plans which guided staff practice.
- People were involved in managing risks to themselves and in taking decisions about how to keep safe. Staff understood people's individual risks and the support they needed. This included whether people needed staff support to access community activities or were able to go by themselves.
- Staff made every attempt to avoid restraining people and did so only when de-escalation techniques had

failed and when necessary to keep the person or others safe.

Preventing and controlling infection
● Staff were observed not wearing personal protective equipment (PPE). On each of the inspection site visits care staff were initially seen not wearing PPE face masks when the inspector arrived at the premises, or not wearing their face mask properly. This increased the potential risk of the spread of infection and was not in line with government guidance in place at the time of the inspection.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises. Apart from the maintenance issues previously detailed (in the section above) the care home was generally hygienic, and the provider had cleaning schedules in place to guide and monitor the cleaning practices of the staff.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider was responding effectively to risks and signs of infection.
● We were assured that the provider's infection prevention and control policy was up to date.
● The service supported visits, for people living in the home, in line with the guidance in place at the time of the inspection.

We have also signposted the provider to resources to develop their approach.

Staffing and recruitment
● People living at the care home at the time of the inspection were supported by enough staff to meet their care needs. The registered manager had recruited additional care staff and covered any gaps in the rota with regular agency staff who understood people's care needs.
● Staff had received appropriate training to enable them to meet people's complex care needs. One staff member told us, "I have received all the necessary training to support the service users in a person-centred way." Another staff member told us, "They give us refresher training to keep us up-to-date in supporting our service user's care."
● The registered manager regularly reviewed staffing levels to meet people's changing needs. A staff member told us, " In the past we did struggle due to being short of staff, but since [registered manager] has come here they have made efforts to put better staffing levels in place."
● Staff were safely recruited. The provider undertook pre-employment checks to help ensure prospective staff were suitable to care for people. A minor issue relating to a missing previous employment reference, for one staff member, was identified and discussed with the registered manager, who took immediate action to rectify the matter.

Using medicines safely
● Medicines were safely managed. People were supported by staff who followed the provider's systems and processes to administer, record, and store medicines safely.
● The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines. Staff ensured people's medicines were regularly reviewed by prescribers.

Systems and processes to safeguard people from the risk of abuse
● People told us they felt safe living at the care home. A person told us, "Yes, I feel safe. I like it here." Another person told us, "Yeah, I'm safe here, if I wasn't people would know about that for definite!"
● People were protected from the risk of abuse. The service had effective safeguarding systems and policies in place; and managed safeguarding concerns promptly, using local safeguarding procedures.
● People were supported by staff who understood how to keep them safe from abuse. The provider ensured

all staff received safeguarding training and had access to information about how to raise any concerns appropriately.
● Staff noted any unexplained injuries on the provider's incident record forms. This included body maps and the registered manager reviewed the incident reports to determine potential causes.

Learning lessons when things go wrong
● Staff understood how to raise concerns and report incidents appropriately.
● The manager reviewed the details of incidents to identify potential causes and any lessons which could be learned to reduce the likelihood of recurrence.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

● We found the service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty. Any conditions related to DoLS authorisations were being met.
● The provider complied with any directions received from the Court of Protection in respect of people who had been assessed as not having the capacity to make decisions for themselves on some aspects of their care.

Good

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At our last inspection we rated this key question Requires Improvement. At this inspection the rating has changed to Good. This meant people's needs were met through good organisation and delivery.

At our last inspection, people's individual needs were not always met effectively by staff due to a lack of monitoring and understanding of people's needs. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 .

At this inspection, we found enough improvement had been made and the provider was no longer in breach of regulation 9.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- Improvements had been made in the way people's individual risks and care needs were assessed. Care plans had been comprehensively reviewed and updated since the arrival of the new registered manager.
- People were involved in developing their care plans by telling care staff how they wanted to be supported. Care plans contained detailed information about each person's individual needs and preferences, their level of independence, and where support from staff was required.
- Care plans were focused on the person's whole life, including their goals, skills, abilities and individual aspirations. This included any protected equality characteristics.
- Improvements had been made in ensuring people's individual care and support needs were met. Staff had a good knowledge of each person and people received the care detailed in their care plan.
- Staff told us a person's willingness to accept support had recently changed, and they had adapted their approach accordingly. The person's care plan was slightly out of date as a result of that change. This was discussed with the registered manager who immediately updated the care plan based on feedback they received from staff.
- Following the previous inspection, the provider had supported a person to change bedrooms to one which was in better condition and which also enabled them to more easily engage in the social interactions within the care home. This had a positive impact on the person's wellbeing and the ability of the staff to monitor and provide care as needed.

Meeting people's communication needs

Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

- The service was able to provide information in a range of formats if needed, and staff took the time to

explain information to people in ways they could understand.
● People had access to key information, such as the complaint procedure, which was displayed in the care home.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them
● People were supported to maintain contact with relatives.
● People's ability to engage in community-based activities had been limited due to general COVID-19 restrictions over previous months. A staff member told us some people had restarted accessing community activities, but some people had "lost the habit" of going out and staff were trying to encourage them to re-engage in activities they had previously enjoyed doing.
● People had individual programmes of activities in place where that was assessed as appropriate for them. This included leisure activities in the care home and in the community. Some people accessed the community without care staff accompanying them, where that had been assessed as being appropriate and safe.

Improving care quality in response to complaints or concerns
● There were systems and processes in place for people to raise complaints with the provider if they wished. A person told us, "If I wanted to complain about something, I would tell the staff. But I haven't complained because I am happy here."
● The registered manager told us they were aware of concerns raised about the service previously, and that they had been working through an action plan to make the necessary improvements. A relative told us, "[Registered manager] has been there for a few months and they are trying hard to put things right."

End of life care and support
● No one was receiving end of life care. However, people had received opportunities to discuss their end of life wishes if they chose to.

Requires Improvement

Is the service well-led?

Our findings

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

At our last inspection we rated this key question Requires Improvement. At this inspection the rating for this key question has remained Requires Improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

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

- The provider's quality monitoring systems were not effective in identifying and resolving the property issues identified in the Safe section of this report. For example, on the first day of the inspection site visits we raised the issue of defective fire doors with the registered manager. They subsequently told us they had reported the issues to their maintenance team and the issues would be rectified by the end of that week. However, we returned the following week and corrective action had not been taken.

We recommend the provider considers their procedure for carrying out maintenance checks on the premises, the process by which maintenance works are prioritised when defects are found, and takes action to update their practice accordingly.

- The provider ensured the management team were supported with information about national best practice guidance; and their policies and procedures reflected current legislation. However, in respect of the use of face masks, as detailed in the safe section (above), this guidance was not always fully followed by care staff.
- Staff told us they had started to see improvements and were hopeful these would continue under the new registered manager. Staff were clear about their role and responsibilities.
- The provider had informed CQC about incidents which they are required to formally notify us about. This helps us to monitor the service.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- A person's relative told us it was often difficult to get through to the care home on the telephone and that staff did not always ring them to let them know the outcome of their relative's medical appointments. They felt families could be more included than they currently were. We raised this with the registered manager who told us they would review how they engaged with people's relatives.
- People's equality and diversity support needs were identified. People's care plans contained details of how the person wanted to be supported.
- People received opportunities to share their views about the service via house meetings and satisfaction surveys. Relatives were also invited to share their views about the service.
- Staff told us, and records confirmed, there were regular staff meetings to discuss and share information

such as improvements required.

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

● People were encouraged to go out and try various new community activities. We saw this was not always successful as some people preferred to stay at the care home most of the time. However, staff told us they continued to try different approaches to encourage people to try new activities.

● A person's relative told us, "[Staff member] went out of their way to do a superb buffet for our relative's birthday a few weeks ago. It was appreciated, and we sent a thank you card to them."

● The registered manager had made improvements to people's care plans and staffing levels and there was an ongoing improvement plan in place. One staff member told us, "I think Heathcotes (Arnold) is improving from the pandemic. At that time things were very difficult, but now I would recommend any person to bring their relatives to live here."

● Staff told us they felt supported by the registered manager.

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

● The registered manager understood their responsibilities to be open and honest with people and their relatives when things went wrong.

Continuous learning and improving care

● The provider had a continuous improvement plan in place and reviewed incidents to identify where care was not being provided effectively. For example, a person had recently moved out from the care home which had led to a significant decrease in incidents. The registered manager had identified the person's care needs could not be safely met at Heathcotes (Arnold).

● The registered manager was aware of their responsibility to ensure proper pre-placement and compatibility assessments were carried out on any potential new applicants to move into the care home.

Working in partnership with others

● The registered manager had been open with other agencies about the difficulties the care home had faced previously.

● People were supported to access community health care services, such as GPs, and specialist healthcare support when needed.

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 15 HSCA RA Regulations 2014 Premises and equipment The provider failed to ensure the premises were properly maintained. Specifically in respect of fire doors, maintenance processes, and the management of household waste. This placed people at increased risk of harm.