Heathcotes Care Limited

Heathcotes (Moorgreen)

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection of this service in November and December 2016 and found breaches of regulation. After the inspection, the provider wrote to us to say what they would do to meet the legal requirements. We undertook this focused inspection to follow up on information of concern received by CQC and check how the provider was progressing with their action plan. This report only covers our findings in relation to those requirements. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Heathcotes (Moorgreen) on our website at www.cqc.org.uk.

We inspected the service on 25 January 2017. The inspection was unannounced. Heathcotes (Moorgreen) provides short term treatment and support for up to eight people who have a diagnosis of personality disorder. The service was relatively new having only been registered since August 2016 and on the day of our visit three people were using the service.

There was a registered manager in place at the time of our inspection. They did not work in the service every day and so were supported by another manager who was managing the service on a daily basis. 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.

We found that systems in place to reduce the risks associated with people's care and support were not always effective and this exposed people to the risk of harm. People were still not adequately protected from risks associated with the environment.

There were not always enough staff to provide care and support to people when they needed it and staff did not always have the skills to ensure the safety of people who used the service. Staff did not always receive suitable training or support to enable them carry out their duties effectively and meet people's complex needs.

There was a risk that people may not receive their medicines as prescribed and medicines were not stored or managed safely.

People were supported by staff who knew how to recognise and respond to abuse and systems were in place to minimise the risk of abuse. Safe recruitment practices were followed.

People who lacked the capacity to make certain decisions were protected under the Mental Capacity Act 2005. Where people had capacity they were enabled to make choices about their care and support.

People were supported to eat and drink enough. People had access to healthcare and people's health

needs were monitored and responded to.

People and staff were involved in giving their views on how the service was run.

There was an ongoing lack of effective risk management and this placed people who used the service at risk of harm. Action was underway to make improvements but this had not yet been fully effective. Systems in place to ensure the safe running of the service were not effective.

We found three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These breaches were in relation to safe care and treatment, staffing and good governance.

The overall rating for this service remains 'Inadequate' and the service therefore remains 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, if needed, could be escalated to urgent enforcement action. 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. 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.

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

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.

Systems in place to reduce the risks associated with people's care and support were not always effective and this exposed people to the risk of harm.

People were not protected from risks associated with the environment.

There was a risk that people may not receive their medicines as prescribed and medicines were not stored or managed safely.

There were not always enough staff to provide care and support to people when they needed it and staff did not always have the skills to ensure the safety of people who used the service.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff did not always receive suitable training or support to enable them carry out their duties effectively and meet people's individual needs.

People who lacked the capacity to make certain decisions were protected under the Mental Capacity Act 2005. Where people had capacity they were enabled to make choices about their care and support.

People were supported to eat and drink enough. People had access to healthcare and their health needs were monitored and responded to.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

There was an ongoing lack of effective risk management and this placed people who used the service at risk of harm. Action was underway to make improvements but this had not yet been fully effective.

Systems in place to ensure the safe running of the service were not effective. People who used the service, and staff were involved in giving their views on how the service was run.	

Heathcotes (Moorgreen)

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 undertaken to explore information received about the service, 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 and to provide a rating for the service under the Care Act 2014.

We conducted an unannounced, focussed inspection of Heathcotes (Moorgreen) on 25 January 2017. The inspection team consisted of two inspectors, one from the adult social care inspection team and one from the mental health inspection team. The team inspected the service against three of the five questions we ask about services: is the service safe, is the service effective and is the service well led. This is because the service was not meeting some legal requirements.

Prior to our inspection we reviewed information we held about the service. This included information received from the service, including statutory notifications, and other sources. A notification is information about important events which the provider is required to send us by law.

During our visit to Heathcotes (Moorgreen) we spoke with two people who used the service. We also spoke with three members of care staff, the acting manager (who was responsible for the day to day running of the service) and a representative of the provider. We looked at the care and medicines records of all three people who used the service, staff recruitment and training records as well as a range of records relating to the running of the service including audits carried out by the management team. We also observed care and support in communal areas of the service.

Inadequate

Is the service safe?

Our findings

During our previous visit we found that the service was not managed safely to minimise risks to people. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. During this visit we found that some improvements were underway but that further improvements were required.

People were still not protected from risks associated with the environment. People who used the service required a significant amount of support to manage serious risks to their health and wellbeing, such as self-injurious behaviours. The environmental risk assessment had been updated following our previous inspection to include some risks present in the environment however it still did not cover all risks in the service. For instance some glass had been removed from the kitchen but other glass and potentially sharp objects such as crockery remained in the kitchen and were not covered by the risk assessment. One person who used the service was identified in their support plan as being at risk of swallowing batteries and we found batteries in remote controls in communal areas. This risk was not included in the risk assessments to ensure the risk to this person was minimised.

Guidance in the environmental risk assessment had not always been updated to reflect current risks within the service and to protect people who were at risk of self-harm. For example we observed that one person's bedroom door had been damaged due to a previous incident and was awaiting maintenance. The door had sharp metal parts exposed which could have been used by someone to harm themselves. This also posed a risk of a person attempting to ligature themselves. Ligaturing is when someone uses a cord like object in an attempt to strangle themselves. All three people who used the service had a history of trying to do this. The acting manager informed us that they were waiting for the door to be mended. However, we saw that this had not been considered in the risk assessment, therefore the level of risk was unclear and there was no evidence that any action had been taken to reduce this risk in the interim.

Room searches had been implemented since our last inspection, however these were not always effective in identifying risks. In addition to this there was a risk that room searches may not be effective as staff did not have a clear understanding of what they were looking for when searching people's rooms. All three people who used the service were at risk of trying to self-harm. Records showed that although staff were identifying some potentially harmful items not all items had been consistently identified by staff conducting the room searches. This reduced the likelihood that staff would remove these items if the person became agitated. For example, we found glass, razors and CD's in the one person's room, these had not been recorded on the most recent room search conducted by staff. The person's support plan showed that they had previously attempted to harm themselves using sharp objects such as those found. In additional to this, records showed that room searches were not always conducted at the required frequency. We spoke with a member of staff who told us that the above person's room checks had not been completed the day prior to our visit. Records showed that no checks had taken place on this person's room since 23 January 2017, two days prior to our visit. Following our visit we received a notification of an incident involving the above person which took place on 24 January, in which they attempted to harm themselves using a sharp object from their bedroom. This may have been avoidable had effective room checks been in place.

In addition to the above we found limited evidence to demonstrate that dangerous items were removed from people's rooms when they were low in mood or distressed, as directed in people's support plans. For example records showed that one person who used the service was presenting as low in mood from 17:30 onwards. An incident record for this date recorded that at 23:00 they were found in their room using sharp objects to harm themselves. This indicated that staff had not taken action to remove potentially dangerous items from the person's bedroom room in response to their low mood. We discussed this with the acting manager who informed us that this was a recording issue and that staff were removing items as directed by people's care plans, however this had clearly not been the case on this occasion.

Night time welfare checks had been implemented following our previous inspection. These were being completed as directed for two people who used the service. However we found that for the third person these were not being completed according to guidance in their support plan. The support plan stated that the person should be observed every 15 minutes overnight or constantly if they showed signs of agitation. Despite this records showed that checks were normally completed every hour. In addition there was no evidence that constant observations were implemented after instances of self-harm. For example records showed that the person was presenting as low in mood and incidents records showed that they had then proceeded to self-harm. Records of night time welfare checks showed that they were checked every half hour that night. This constitutes a clear example of where constant supervision should have been implemented as per the support plan.

We found multiple issues related to the administration, recording and storage of medicines. People could not always be assured that they would receive their medicines when they needed them. We reviewed staffing rotas and found that there was not always a member of staff on shift at night who was trained to administer medicines. We spoke with a member of staff about this who informed us that if someone needed medicine at night, staff would contact staff from neighbouring services to administer this or contact the on call manager. One person who used the service was prescribed emergency medicine to be administered in response to an allergic reaction. The system in place did not assure us that this person would be provided with medication in a timely manner in the event of an emergency. Furthermore, one person we spoke with told us, that they said that they do not always get their medicine at night as there were not always trained staff available.

People's medicines were not stored safely to ensure they were at their most effective. There were systems in place to record the temperature of the medicine room however staff were not always completing these temperature checks. For example the last recorded temperature check of the medicine room had been on 21 January 2017, three days prior to our visit. We found multiple occasions where the room had been recorded as being above the recommended level of 25°C. On two occasions it had been noted that ice packs had been used to cool the room, however on other occasions no action had been recorded to address this. This could have had an impact on the efficiency of medicines. We spoke with the acting manager about this who told us that ice packs were used to cool the medicines room when needed, however they were unaware that the temperature of the medicines room had not been recorded for the three days prior to our visit and consequently no action had been taken to rectify this.

When people were prescribed medicines 'as required' (known as PRN) there were not always protocols in place to ensure that staff were aware of when to administer these medicines. Where protocols were in place they did not provide sufficient detail to enable staff to make an informed decision about when to administer the medicine. For example one person who used the service was prescribed a PRN medicine to help control anxiety. There was a protocol in place related to this but it did not detail what methods staff should try prior to the administration of medicine. This lack of PRN protocols had also been identified as an issue in our previous inspection. We spoke with the acting manager about this who told us that they had recently written

new protocols and they were waiting for the GP to sign them. However they had not yet been put in place.

People's medicines records did not contain details of people's allergies or information about how the person preferred to take their medicines, which meant that staff did not have access to all the necessary information about how to support people to take their medicines safely. The acting manager informed us that they had written these but they had not yet been put in place.

Medicine administration records (MAR) had not always been fully or accurately completed to show that people had received their medicines as intended, for example in two people's medicines records there were occasions where the administration of medicines had not been recorded. Handwritten entries on MARs were not always signed or witnessed by a second member of staff, to ensure that accurate information about people's medicines had been documented. We saw a number of handwritten entries in one person's medicines records. One entry was not signed at all and another four handwritten entries were signed by one member of staff but had not been signed by a second member of staff. This is important to prevent errors. We also found that one handwritten entry was a duplicate of a printed entry. This increased the risk of a medication error.

People could not always be assured that incidents would be responded to appropriately. We reviewed incident records for one person and identified concerns related to the response to incidents. For example an incident record had been completed for this person in relation to an incident on 25 December 2016. The record stated that the person had harmed themselves with glass and had then proceeded to swallow glass in the presence of staff. The record then stated that staff had settled them and they had slept soundly. There were no records that medical attention had been considered or sought in relation to this. We discussed this with the acting manager who informed us that they had spoken to the person on the phone at the time of the incident and they had informed them that they did not actually swallow the glass. Based upon this information the manager made the assessment that there was no need for medical attention and advised staff accordingly. However this advice was not recorded in any of the records we reviewed.

All of the above information was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our previous inspection we identified concerns about staffing levels at the service, in particular at nights. During this visit we were informed by the management team that staffing levels at Heathcotes (Moorgreen) had been increased. The acting manager informed us that day shifts were staffed by three, four or five staff and records confirmed this to be the case. We reviewed staffing rotas and found that night shifts were normally covered by two staff members, occasionally three. There were still not sufficient numbers of staff available over night to safely carry out physical intervention in response to behaviour people displayed which may challenge staff . One person who used the service had a crisis plan which stated that three staff may be required to provide support should physical intervention be needed to keep the person and others safe. Although staff explained that they would contact staff from the neighbouring service for support or call the on call manager this system would not provide responsive, timely support should it be needed. This put the person and other people using the service at risk of harm.

We received mixed feedback about staffing levels. People who used the service told us that they felt that there were normally enough staff. Staff told us that there were enough staff to ensure that people received their one to one support, however also said that there were times when staffing levels were not sufficient. We spoke with one member of staff who told us that there were not always enough staff and that this could be frustrating for people who use the service. Another member of staff told us that they felt there were not enough staff, especially at night. The staff member explained that there were sometimes not enough staff to

manage behaviours people may display or to support activities and that the staff are expected to "just manage." One member of staff we spoke with also explained that there were times when there was just one member of staff and one person who used the service in the unit alone, this may put people at risk of not receiving the support they required in the event of a crisis should physical restraint requiring more than one member of staff be needed.

People could not be assured that they would be supported by appropriately skilled staff to maintain their safety. Records showed that there were some shifts where there were no staff on duty who were trained in the safe removal of ligatures. This meant that if someone tried to harm themselves in this way during the night, there would not always be a trained staff member present to remove the ligature safely. For example on 10, 11 and 18 of January records showed that none of the staff who worked night shifts had been trained in ligature removal. All three people who used the service were known to be at risk of applying ligatures and this lack of appropriately skilled staff put people at risk of harm.

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

The acting manager told us that staffing levels were flexible and could be adapted in anticipation of people's needs. For example one person who used the service had recently had a potentially anxiety provoking meeting. The acting manager explained that they had ensured a higher staffing level following this to ensure that any impact on the person's behaviour could be well managed by the staff team.

People who used the service did not always feel safe at Heathcotes (Moorgreen). Both people we spoke with told us that they did not always feel protected from the behaviour of other people who used the service. One person told us, "I don't feel safe when [name] is on one." Another person told us that they "sometimes" felt safe but went on to speak of recent incidents that made them feel unsafe. We spoke with the management team about this who were aware of the issues and informed us that they were taking action to try and resolve them.

There were systems and processes in place to minimise the risk of abuse and staff had received training in protecting people from abuse. Staff we spoke with had an understanding of how to recognise allegations or incidents of abuse and understood their role in reporting any concerns to the management team and escalating concerns to external agencies if needed. One member of staff we spoke with said, "I always challenge things, listen to concerns and pass things on to management. I document everything." Staff were confident that any concerns they raised with the management team would be dealt with appropriately. Records showed that the management team had shared information with the local authority when needed.

During our previous inspection we found that doors that were designed to ensure that people could not barricade themselves in their rooms had been damaged in incidents and were not functioning as intended. During this visit we observed that maintenance had been performed on the doors and we were informed by the acting manager that staff were now able to gain access to people's bedrooms in the event an emergency in just over 30 seconds.

People could be assured that safe recruitment practices were followed. The necessary steps had been taken to ensure people were protected from staff that may not be fit and safe to support them. Before staff were employed criminal records checks were undertaken through the Disclosure and Barring Service (DBS). These checks are used to assist employers to make safer recruitment decisions. We also saw that proof of identity and appropriate references had been obtained prior to employment and were retained by the provider.

Requires Improvement

Is the service effective?

Our findings

During our previous inspection we found that staff did not have the necessary training or support required to support people safely. During this inspection we found that whilst some improvements were underway further improvements were required to ensure staff had the skills and knowledge to support people safely and effectively.

During our last inspection we found that only three staff had completed the advanced level training which was necessary to use specific types of physical intervention. During this inspection we found that this had increased to nine of the 17 staff employed to work at Heathcotes (Moorgreen). One person's care plan stated that this type of restraint could be used with the person in a crisis situation. However staffing rotas showed that there still not always enough staff trained in this approach to support this person safely. Following our visit the acting manager informed us that staff had been booked onto forthcoming courses to ensure that there were enough staff available to respond to people's needs effectively in a crisis.

Staff did not always receive adequate support or debrief following incidents. We found that there were still no formal systems in place for supporting staff following serious incidents that could be potentially distressing for staff. The acting manager told us, "We have a new incident form that we are just introducing and this has information about debrief on it." One member of staff told us that shifts could be stressful and staff "soak up" what has happened at work. All three members of staff we spoke with informed us that they were not routinely offered a formal debrief. One member of staff told us, "We debrief informally in the car on the way home." Debriefing would offer staff support to discuss the events of the incident and reflect on what went well and what could have been done differently.

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

Feedback from people who used the service about the competency of staff was variable. Whilst one person told us, "Staff are trained and know what they are doing," another person said, "Staff don't understand personality disorder.

We saw records which showed that staff had up to date training in a number of areas including safeguarding, personality disorder, equality and diversity and health and safety. Staff were positive about the training they had received and told us that they could request additional training. Staff also received Dialectical Behavioural Therapy (DBT) training which was the therapeutic approach used in the service. This training was provided by the specialist dialectical behaviour therapists employed by the provider. Despite this training staff knowledge in this area was variable and staff reported a lack of understanding of the therapeutic principles of DBT. We spoke with two members of staff who told us that they did not feel confident with what DBT was. Another member of staff explained that the team did not use the skills outside of the classroom and told us that they felt that staff should have more than one day's training and be involved more in the DBT sessions. This had been identified by the management team and records of staff meetings showed that ideas for improvement had been discussed, such as, the introduction of DBT skills

trainers.

Staff were not always clear on their role, the staff we spoke with gave variable feedback on their understanding of their responsibilities. We spoke with a member of staff who had very recently been promoted to a more senior position in which they were responsible for running shifts, they told us, "I'm not one hundred percent sure on the role yet." However, we spoke with another member of care staff who told us that they had a good understanding of their responsibilities and told us, "I know what is expected of me, to support people to live independently."

Records showed that staff were provided with an induction period when starting work at Heathcotes (Moorgreen) including training, shadowing experienced staff members and reading care plans to learn about the needs of people using the service. New staff had completed or were in the process of completing the Care Certificate. The Care Certificate is a recently introduced nationally recognised qualification designed to provide health and social care staff with the knowledge and skills they need to provide safe, compassionate care.

Staff we spoke with told us they had regular supervision meetings, and records confirmed this to be the case. In addition to this staff had the opportunity to attend a regular sessions with the two Dialectical Behaviour therapists who visited weekly to discuss any concerns or issues related to people who used the service.

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 mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

During our previous inspection we found that people's rights under the MCA were not protected as MCA assessments and best interest decisions were not always in place as required. During this inspection we found that improvements were underway. Since or last inspection action had been taken to ensure that mental capacity assessments were in place as required. Assessments of people's capacity in relation to specific decisions had been carried out when their ability to make their own decisions was in doubt. If the person had been assessed as not having capacity to make a decision, a best interest's decision had been made and this was cross referenced with the persons support plan.

Where people had fluctuating capacity this had been recognised and people's support plans contained clear details of the circumstances in which the person may and may not have capacity. However the management team had not considered the need to record time-specific assessments of capacity, for example, in relation to people's ability consent to having their bedroom's searched. We discussed this with management team who told us that they would consider this in the future.

Staff had a basic knowledge of the MCA but were not able to clearly describe how the principles applied in their role. We spoke with two members of staff who told us that all the people who used the service had capacity to make all decisions. This contradicted some of the capacity assessments we saw and demonstrated a lack of understanding of the principles of consent and capacity. Whilst staff had received information about the MCA in their induction very few staff had in depth training in this area.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application 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 in relation to DoLS and whether any conditions on authorisations to deprive a person of their liberty were being met.

Applications for DoLS had been made where appropriate to ensure that people were not being deprived of their liberty unlawfully. People who used the service had been involved in the DoLS process and had an understanding of how this impacted upon their support. Support plans contained specific information in relation to restrictions placed on people's lives to ensure that they were the least restrictive option.

People were protected from the use of avoidable restraint. People who sometimes communicated through their behaviour were supported by staff who recognised how to support the person and how to respond in a positive way. There were support plans in place informing staff of what may trigger the behaviour and detailing how staff should respond. We spoke with a member of staff who had a good understanding of how to protect people from inappropriate physical restraint, they explained that they always tried verbal redirection first and told us that physical restraint was only used as the last resort.

Where people had capacity they were supported to make decisions. Throughout our visit we observed staff enabling people to make informed choices and gaining their consent. People's support plans detailed how to support people to make decisions to maximise their choice and control.

People were supported to eat and drink enough. People who used the service were involved in developing menus and planning meals. A member of staff told us, "People write their own menu, we advise them towards healthy eating." We observed that people had access to frequent snacks throughout the day and were also supported to access the kitchen and help themselves to drinks. Mealtimes were flexible to suit people's routines and preferences.

People's nutritional needs were monitored and there were support plans in place with clear details of the support people required in this area. Two people who used the service had expressed a preference to lose weight. There was information in their support plans relating to this and during our visit one person was supported to attend a community based slimming club. A member of staff told us, "We have two people on [slimming programme] it's been very successful." Where people had risks associated with eating and drinking there was clear guidance in their support plans.

People were supported with their day to day healthcare needs and were given support to attend regular appointments. People had their healthcare needs detailed in both their support plan and in a health action plan. Records showed that staff sought advice from external professionals when people's health and support needs changed. Staff made referrals to physical and mental health specialist teams when advice and support was needed and we saw the advice received was included in people's support plans and acted on. Where people had specific health conditions their support plans contained information about the condition and guidance for staff about how to respond to any changes. For example, one person had a health condition which was controlled by their diet. Their support plan identified risks associated with eating certain types of food, measures that were in place to reduce this risk and information about how to recognise that the person may be becoming unwell.

People who used the service had access to a range of specialist professionals who were employed by the provider. This included a consultant psychologist and a specialist occupational therapist who attended the service two days a week to provide therapy and support to people who used the service and to provide specialist support and supervision to the staff team. The acting service manager also told us that they were working on developing new support plans to incorporate guidance into people's support plans.

Requires Improvement

Is the service well-led?

Our findings

In our November and December 2017 inspection in we found concerns related to leadership and governance at the service and found that a failure to act upon issues resulted in people who used the service being placed at risk of harm. During this inspection we found that whilst some improvements were underway further improvements were still required to ensure people received care that was safe.

Following our previous inspection the provider issued us with an action plan and at our request they provided an updated action plan on 12 January 2017. During this visit we found although the action plan had been successful in some areas it had not brought about all of the improvements required.

Action taken by the management team was still not sufficient to protect people from risks associated with their care and support. The provider told us in the action plan that by 20 December 2016 the general workplace risk assessment would be updated to detail environmental risks relating to each person who used the service. During this visit we reviewed the risk assessment and found that whilst this had been updated to include some risks such as risks relating to self-harm it still did not consider all risks present in the service, or the control measures in place to reduce these risks Additionally there was a lack of emergency procedures in relation to the environment.

Actions planned to improve the quality and safety of the service had not always been completed in the timescales specified by the provider. For example, the provider told us in their action plan that support plans would be reviewed to ensure that staff had clear guidance to enable them to deliver effective support. This action had been marked as completed in the updated action plan received by us on 12 January 2017. However, during this visit we found that only one plan had been updated, which showed the providers action plan had not been adhered to. The new support plan for one person was detailed, thorough and easy to read, however, the other two care plans had not yet been amended. This had resulted in ongoing inaccuracies in people's care plans and exposed them to the risk of receiving support which was not safe. For example, in our December visit we found that one person's support plan stated that glass should be removed from their room due to a risk of harm to the person. Following our inspection the provider informed us that guidance from the person's social worker was that glass should only be removed if the person was low in mood. Despite this we found that the person's care plan had not been amended to reflect the social workers advice. The acting service manager informed us that they were in the process of updating the other two support plans.

The action plan stated that a new incident form had been implemented which incorporated a debrief for staff and service users. However when we visited on 25 January this incident form had only just been implemented and only one incident had been recorded using the new process. This had resulted in a continued lack of debrief for staff. This lack of swift action by the provider meant that staff still did not receive support following potentially distressing incidents.

The provider did not have effective systems in place to observe and review day to day practice within the service and this resulted in action not being taken to resolve issues. For example we found examples of poor

record keeping and maintenance issues that had not been identified by the management team and consequently no action had been taken to resolve these issues.

Decisive action had not always been taken in response to known issues. For example during our visit we shared our concerns in that there were not enough staff trained in ligature removal. This had resulted in untrained staff supporting people who were at risk of applying ligatures. The management team were aware of this issue and a representative of the provider told us, that this was "disappointing" as there had been recent training available to staff but that staff from Heathcotes (Moorgreen) had not attended. This resulted in people continuing to receive support from staff who did not have the appropriate skill to maintain their safety.

Clear and up to date records were still not always kept of care and support provided. We found that incident records were not always fully or accurately completed. For example an incident record relating to an episode of self-harm did not contain a record of advice given by the on call manager and consequently it appeared that appropriate action had not been taken in response to the incident. In addition to this we found some records of care and support were not dated and so it was difficult to ascertain when the record had been created or reviewed.

During our previous inspection we found that governance systems in place to ensure the safe running of the service were not effective. During this visit we found that a monthly audits conducted by a regional manager were still not effective in identifying issues. Furthermore, action was not always taken to resolve the issues that were identified in the audit. For example an audit conducted in December 2016 stated that action was required to, 'ensure that medication is signed for and correct codes used'. The action plan stated that this would be resolved within two weeks but we found that was still an issue. There had been no audit visit conducted by the provider's compliance team since our previous inspection, this was in progress on the day of our visit, consequently we were unable to make a judgement about the effectiveness of this audit.

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

There had been a continued failure to notify CQC of events in the service, records showed that we had not been notified of multiple incidents involving the police and incidents of self-harm. A notification is information about important events which the provider is required to send us by law. A failure to notify CQC of incidents has an impact on the ability of the CQC to monitor the safety and quality of the service.

This was a breach of regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

There was a registered manager in place they did not oversee the day to day running of the service. The provider had recently recruited a service manager and they were planning to make an application to the CQC to register, however they had not yet started in post. In the interim an experienced manager from another of the provider's services was running the service. Staff were positive about the management team. One staff member commented, "[Acting manager] is a good leader and makes us feel valued, another member of staff told us, "[Acting manager] has brilliant management skills, they are open." The acting manager was supported by a regional manager and also had support from other senior staff employed by the provider who visited the service regularly.

Staff we spoke with told us that they felt that the management team had made improvements to the service. One member of staff told us, "Improvements have been made since the last inspection, staffing and new folders have been put in place." Another member of staff told us, "They have listened to CQC and have made

a lot of changes." It was clear that improvements had been made in some areas, for example in our previous inspection we found that the anti-barricade doors were not functioning effectively, during this visit we found that the doors had been mended and were now functioning as intended. In other areas work was still underway to improve or resolve some of the concerns we raised at our previous inspection. For example a number of new processes had been introduced such as night time welfare checks and room search procedures and these were still in the process of being implemented. The management team had been proactive in identifying some other issues and were in the process of taking action to try to resolve them. For example they had identified issues with the integration of the therapeutic model and we saw records to demonstrate that the team were working on ways to improve this.

During our previous inspection we found that appropriate action was not taken in response to incidents to minimise the risk of reoccurrence. During this inspection we saw evidence to demonstrate that the management team had made improvements based upon learning from accidents and incidents. For example we were notified of an incident in late December where someone who used the service had gained access to the service's car putting themselves and others at risk. During our visit we saw that a risk assessment had been put in place in relation to this and the provider also notified us that they had made changes to ensure that car keys were stored securely.

People who used the service were supported to have a say in how the service was run. Regular meetings were held for people who used the service. We saw records of these meetings which showed that they were used to discuss health and safety and staffing. Staff were also given an opportunity to have a say in the running of service in regular staff meetings. One member of staff told us, "There have been a couple of meetings, the first one was general and the second was about changing hours, room checks and safeguarding." Records of staff meetings showed that these were used to provide feedback to the team, discuss improvements required and to address areas such as safeguarding and health and safety. Staff told us that changes were made based upon their feedback. For example in our previous inspection staff told us that the shift pattern was challenging and we saw that they had recently raised this with the provider. During this visit we saw that changes had been made to shift patterns based upon this feedback. One member of staff told us, "It's much better and has improved the atmosphere."

Staff told us they were happy working at Heathcotes (Moorgreen), one member of staff told us, "It's a nice culture, I enjoy coming to work," another staff member said, "When we work together and [people who use service] do things independently it makes me feel proud." Staff were aware of their duty to raise concerns about poor practice and felt confident in discussing any concerns with the management team. One member of staff told us, "I would raise any concerns, but I haven't had any."

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 Registration Regulations 2009 Notifications of other incidents Statutory notifications were not submitted to the CQC. Regulation 18 (1) (2)